CASE 1

The US Health Care System – Participants, Financing, and Trends: An Industry Note

OVERVIEW

This case is actually an "industry note" that provides a snapshot of the current health care system by describing the significant organizational and professional providers and the major purchasers or "payors" for health care services. A background description of the key historical events and their effects on health care services is included as well as a description of the rapidly changing current environment.

Over the past 50 years, health services have been affected by three basic trends: growth in scientific knowledge, growth in the financial resources allocated to health services, and changed relationships among health care providers, payors, and health care consumers. A number of significant events contributed to these trends (Exhibit 1/4 contains an excellent list). As a result of these events, health care grew faster than any other segment of the US economy. Thus, health care expenditures, measured as a percentage of gross domestic product (GDP), that were 7.4 percent of GDP in 1970, now approximate 15 percent of GDP.

Although the health care sector grew dramatically, the growth was uneven. The percent of total expenditures attributable to the hospital sector declined during the past 20 years. By 2002, the figure stood at 31.3 percent (in 1980 hospitals accounted for 41 percent of health services). The downward trend was related to a real decline in inpatient admissions over this 20-year period. However, the most recent data suggests that although average length of stay for a hospitalized patient continues to decline, the number of hospital admissions posted a small increase and the total number of days of care delivered in the inpatient setting has also slightly increased. The utilization of hospital outpatient services has increased dramatically during this period.

Physician services made up the largest single professional service component of the health services sector. Payments to physicians accounted for 21.9 percent of total health services expenditures in 2002, slightly less than what it was a decade earlier. Nursing home and home health services accounted for 9 percent of national health care expenditures in 2002 (a significant increase over 1960 when nursing home care used 3.4 percent of the health care dollar).

Between 1960 and 1990, the portion of the domestic health care dollar devoted to products from pharmaceutical companies and other medical suppliers actually declined. In 1960, drugs and other medical products accounted for 18.5 percent of health care expenditures. By 1990, the proportion had decreased to 10.5 percent; however, by 2002 the proportion was 13.7 percent and projected to continue to increase. Increasing expenditures on prescription drugs accounted for much of this increase.

This teaching note was written by Stuart A. Capper, Tulane University. It is intended as a basis for classroom discussion rather than to illustrate either effective of ineffective handling of an administrative situation.

In the past, households paid for most health services through direct out-of-pocket health spending by individuals; premiums paid as employees (or the self-employed paid into the Medicare hospital insurance trust fund); premiums paid by individuals to the Medicare supplemental medical insurance trust fund; and individual health insurance policies. During the 1970s and 1980s employers assumed an increasing burden for the costs of health care, but the burden was becoming too much for many of them. Using various managed care methods, employers stabilized their share of health care expenditures; however, the share being paid by governments continued to increase. Over the 30-year period from 1970 to 2000, while health care expenditures increased, individual households were paying a decreasing proportion of the total bill. In dollar terms, all payors faced increasingly larger health care bills. However, individual household expenditures were increasing much more slowly than government or private business. During this same period, medical technology was increasing at a very rapid rate. Therefore, although individuals were paying more, they saw increasing benefits from their expenditures. Consumers were paying more, but in their eyes, the additional dollars they allocated to health services was buying quite a lot. The subsidies for individual health services provided by government and business help explain why it has been difficult to gain national consensus on the extent of the health care cost and access problem.

Current environmental trends that are affecting health care delivery include:

1. Declining hospital utilization resulted in beds being taken out of service (equivalent to closing seventeen 200-bed community hospitals in every state since 1985). The most recent data suggest that after a 15- to 20-year period of reductions in hospital beds, we may be seeing a slight increase in the number of community hospital beds in active service.
2. Managed care in the private and public sector was increasing throughout much of the decade of the 1990s including Medicare and Medicaid efforts to move enrollees into managed care organizations (MCO). Increasing enrollment but decreasing numbers of managed care organizations resulted in fewer MCOs with larger numbers of enrollees in each MCO. Such a trend suggested increasing bargaining power for managed care organizations when they negotiated with providers such as physicians and hospitals. By the end of the decade the trend was less certain. Support for traditional managed care approaches of cost containment by private business was decreasing. Businesses were experimenting with a broad range of interventions to control employee health care costs.
3. The physician workforce was changing as the availability of active physicians increased from 190 per 100,000 population in 1980 to 274 per 100,000 in 2001. In addition, other professionals, including nurse practitioners and physicians' assistants, were serving patients' needs and, in some cases, allowing individual physicians to manage more patients.

With this overview of the health services sector, students should have a better grasp of the issues facing health care leaders.

KEY ISSUES

Discussions of the strategic issues that will broaden the student's perspective include:

1. Allocation of health care resources in the United States. Will there be significant changes to the methods we currently use to allocate resources? If so, what are the changes likely to be? How quickly will they take place?
2. Identification of health care trends. What are the trends that have occurred in health care over time? Which of these trends are likely to continue? Which are likely to change? What assumptions are made that lead to the conclusions reached?
3. Impact of the changing health care environment on payor groups. How are private businesses and government (federal and state) impacted by the changes in resource allocation methods in health care? How might these changes affect consumer choices about their health care?
4. Impact of health care inflation on various consumer segments. Will employment status continue to provide access to health care? Will the elderly continue to have access (Medicare)? The poor and infirmed (Medicaid)?
5. The competitiveness of the health care system. How has competition in the health care industry changed over the past few decades? Have these competitive changes been "good" for health care?
6. The changing nature of health care cost allocations. How have health care expenditures changed over the past 20 years? What impacts, if any, are these changing allocations having on patient care?
7. The role of regulation in a competitive health care environment. Should regulation in the health care industry be focused on allocating health care resources or perfecting the competitive market and allowing market forces to allocate resources?
8. Advances in electronic medical records and health informatics. Will hospitals and physicians readily adopt electronic medical records? What impact will the digital information revolution have on health care?

TEACHING OBJECTIVES

1. To provide background information for the analysis of health care cases that helps to "level the playing field" among students.
2. To provide a "snapshot" of the health care system as it exists today in terms of major provider categories, payor categories, users of health care goods and services, and environmental trends.
3. To identify and analyze changes most likely to occur in the health care system over the near term.
4. To understand historical trends in the health care environment and to speculate on the likely future course of these trends.
5. To foster strategic thinking.

SUGGESTIONS FOR EFFECTIVE TEACHING

At the time this Industry Note was being written, the ongoing national policy debate over health care was somewhat subdued. On September 11, 2001, the World Trade Center tragedy

in New York City focused much of the attention of US citizens and our national leadership on terrorism and the resulting war. Managed care attempted to better control rapidly escalating health care costs and change the way health care resources were allocated. And, for a time, managed care did lower costs. But then, a combination of factors, including stronger competition from physicians and some hospital groups, the perception by consumers of abuses by managed care companies, and the continuing advancement of medical technology, began to weaken managed care cost control efforts. The national debate over health care cost, access, and quality will not go away and will likely intensify as employers, state and local governments, and the federal government attempt to stabilize their escalating health care costs with a variety of methods to raise consumer consciousness of costs and to increase use of services to prevent illness and better manage existing medical conditions.

There are several ways to use this Industry Note. The first approach is to assign the Note prior to assigning any of the other health care cases. This approach ensures a common frame of reference for students. It is a method to "level the playing field" for those students who do not have as much background or experience in the health care field. We have found that using the Note in this way greatly enriches class discussions and improves the quality of analysis for all subsequent cases.

Alternatively, the Industry Note may be used as a case study. If this approach is selected, it is useful to orient the students to the advisor or consultant role. Using individuals or small groups, the students should consider whether they would advise a health care organization to expand, contract, or maintain its scope in the industry. In this orientation, the students must explore the issues underlying the use of expansion, contraction, and maintenance strategies. Such strategic alternatives relate to the major industry issues cited in the Key Issues section of this note. In addition, students may identify particular market niches for which they see substantial opportunities or threats.

Another alternative approach is to assign students the task of updating specific sections of the Industry Note. The publication process is slow and the health care environment is undergoing rapid change. By the time this book was printed late in 2005, a number of significant changes probably have already occurred.

QUESTIONS FOR CLASS DISCUSSION

1. What will the health care industry be like five years from now?

Early in the class discussion, we ask the students this question. The best answers have been fairly specific and well structured with a clear rationale for the description. Though the approaches vary widely, students typically examine the industry through market sectors (acute hospital care, physicians services, nursing home care, or rehabilitation services); categories of key health care organizations (for profit and not-for-profit hospital systems, health maintenance organizations, preferred provider organizations, or medical and allied health education); or key industry trends (growth in supply of physician services, reduction

in supply of inpatient hospital beds, growth of ambulatory services, consolidation of the managed care market, and so forth).

2. Consider an increasing supply of physicians, a decreasing ratio of people per active physician, an aging US population, and increasing medical technology. Over the next decade, what impact might this have on other health professions such as nursing, health administration, and public health? What impact might this have on how physicians make judgments about patient care?

This question requires that the students consider history to some degree. How did the health professions change when the trends cited in the question were different? What happened to nursing, health administration, and other health professions when we had a physician shortage and demand for specialty care was rapidly increasing? How did the way we paid for health care at that time influence the historical picture? How will the changing payment environment influence the future? Cost-based reimbursement in the 1960s, 1970s, and early 1980s allowed providers to differentiate jobs and rapidly expand the workforce. Current trends increasing the use of capitated payments and pre-negotiated fixed fees encourage other types of provider behavior. Induce the students to consider the changing environment for physician's services and what opportunities and threats this creates for other health professions. Will increasing competition for patients and incentives to treat more patients have an impact on how physician practice? Which specialties will be in demand and which will see competition for limited numbers of patients?

3. What are the approaches for conducting external environmental analysis? What are the advantages and disadvantages of each? Choose one approach and apply it to a health care organization in your community.

Environmental analysis attempts to surface the issues that will be important to health care organizations. A number of approaches can be used to scan, monitor, forecast, and assess the health care environment. These approaches are summarized in the table below.

Rather than everyone suggesting the local hospital, encourage students to select from a variety of organizations (a local long-term care facility, a large clinic, the local public health department, an urgent care center) to discuss a response to this question. Most any of the techniques can be applied. Thus, the rationale that the student provides for why he or she chose that particular technique should enhance the discussion and learning environment.

Technique	Focus	Advantage	Disadvantage
Simple Trend Identification and Extension	Scanning Monitoring Forecasting Assessing	• Simple • Logical • Easy to communicate	• Need a good deal of data to extend the trend • Limited to existing trends

			• Does not foster creative thinking
Delphi Technique	Scanning Monitoring Forecasting Assessing	• Use of field experts • Avoids intimidation problems • Eliminates management's biases	• Members are physically dispersed • No direct interaction of participants • May take a long time to complete
Focus Groups	Forecasting Assessing	• Uses experts • Management/expert interaction	• Finding experts • No specific structure for reaching conclusions
Nominal Group Technique	Scanning Monitoring Forecasting Assessing	• Everyone has equal status and power	• Structure may limit creativity
Brainstorming	Forecasting Assessing	• Fosters creativity • Develops many ideas and alternatives • Encourages communication	• No process for making decisions • Sometimes gets off track – ideas too creative to be useful
Dialectic Inquiry	Forecasting Assessing	• Surfaces many sub-issues and factors • Conclusions are reached on issues	• Does not provide a set of procedures for deciding what is important • Considers only a single issue at a time
Stakeholder Analysis	Scanning Monitoring	• Considers major interdependent groups and individuals • Assumes major needs and wants of outside organizations are taken into account	• Emerging issues generated by other organizations may not be considered • Does not consider the broader issues of the general environment
Scenario Writing	Forecasting Assessing	• Portrays alternative futures • Considers inter-related external variables	• Requires generous assumptions • Always a question of what to include • Time consuming

4. Of the strategic issues facing health care organizations today, which ones are likely to receive attention? Which ones should receive attention?

This question presents an opportunity for students to address strategic issue diagnosis (SID) for the health care sector (or it can be limited to a particular type of health care organization in your area where there are many emerging issues – physician practices, long-term care, home care, or acute care). The issues provided under "Key Issues" in this note provide a list that we feel will require addressing over the next several years for the health care sector. For many of these issues, our society has not determined what we should do to ensure access and quality at a cost that citizens can afford. For other issues, health care providers have not decided how they will deal with the evolving trends. Have we reached a strategic pressure point on any of these issues? As of the end of 2005, probably not; but, over time, they continue to boil. For example, the use of electronic medical records and other digital information processing techniques will have an impact on how health care is delivered. Will these methods increase quality and reduce medical errors? How will the doctor/patient relationship be affected? Will these methods increase or decrease costs? How will patient privacy be maintained?

As the public has to pay for the increased costs of security in the United States, the increasing costs of energy globally, and the increasing costs of imported goods and services, will we also be able to pay for the increasing costs of Medicare and Medicaid? Pressures on Medicare and Medicaid are likely to increase further given the impact of globalization on the US workforce (outsourcing, manufacturing-based economy being replaced by services-based economy, and so on) and the aging US population (heavy users). The pressures (issue urgency) may force us to look at the issue, but at this time we do not have great capacity (feasibility) to resolve the issue. Individuals may be called on to bear a greater burden of health care costs as private business uses various financial incentives to increase consumer consciousness of inefficient providers (cost shifting increases again). As more and more businesses find themselves competing in a global marketplace, they may attempt to shift more and more of the costs of employee health care to the individual.

Each of the many issues can be looked at and discussed by the students. The perspectives will no doubt be very diverse as our health care system is complex and we have had little success in determining ways to "fix" the system. Experimentation with new ways to "manage" health care will continue and the health care environment will be anything but stable. Unstable environments create opportunity and our students should be well prepared to create personal and societal value from the future for health care.

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CASE 2

Methodist Healthcare – Managing for the Future

OVERVIEW

This case describes the unique issues faced by health care leaders in strategically managing integrated health care delivery systems. Gary Shorb was appointed CEO of Methodist Healthcare in 2001. Mr. Shorb decided that a major strategic planning effort was required to lead the organization into the future. During the transition process, the executive leadership team was assembled to complete the strategic management process. The team performed situational analysis and developed a new vision statement along with the goals and the various strategies to achieve the goals. This is a decision-based case that requires students to examine and understand the results of the situational analysis, their impact on Methodist Healthcare, and determine recommendations for managing the strategic momentum. Students will be asked to develop strategies that answer the questions posed by Mr. Shorb to his leadership team.

KEY ISSUES

1. Strategic management in a rapidly changing health care environment.
2. Achieving strategic focus in a decentralized, not-for-profit organization.
3. Analyzing organizational structure and focus.
4. Understanding the environment to determine appropriate strategies.

TEACHING OBJECTIVES

After analyzing the case, students should be able to:

1. Understand the complexity of strategic planning for health care organizations given the uncertainties and pressures such institutions face.
2. Appreciate the pressures health care providers encounter to reduce costs while delivering quality medical care.
3. Understand that no decision is "easy" – especially contraction/divestiture strategies that are sometimes necessary and assist in achieving the overall financial objective.
4. Integrate a vision statement to guide strategic decision making.
5. Recommend decisions regarding the development of strategies and implementation plans.

This teaching note was written by Mary C. Christy, Administrative Director for Strategic Planning, and Gary Shorb, CEO, Methodist Healthcare. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case engages students by requiring them to deal with strategic issues that are faced by large health care systems. The information provided can be organized for either written or in-class presentation. The student is expected to develop an environmental assessment and an internal analysis using decision support tools such as the TOWS matrix. It is also expected that careful analysis of alternative strategies will indicate a recommended strategy and plans for implementation.

Given the dynamics of the case, it is recommended that the instructor consider utilizing role-playing techniques for classroom discussion. The students can assume the roles of the leadership team illustrated in Exhibit 2/1 of the case and complete the strategic management process while analyzing the case in the classroom. The students can then comment on the usefulness of the methods presented in the text to stimulate strategic thinking.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Methodist Healthcare's internal strengths and weaknesses and external opportunities and threats is provided below.

Internal Strengths

1. The leadership team has significant experience within the Methodist Healthcare system.
2. Strong external and internal customer/client orientation.
3. Commitment to a high level of service quality.
4. Methodist Healthcare is a faith-based health care system.
5. Strong physician relationships.
6. Strong ties with The University of Tennessee.
7. Methodist Healthcare is the largest hospital in Memphis and the Mid-South.
8. Commitment to technology.
9. Commitment to associate education (MELI).

Internal Weaknesses

1. Financial loss associated with the West Tennessee operations.
2. Losses from acquired physician practices.
3. High Medicare/Medicaid/TennCare payor mix.
4. Organizational culture lacks sense of urgency to respond to the changing environment.
5. Under capitalized for funding future growth.

External Opportunities

1. Greater demand for quality patient care by the public.
2. A growing elderly population continues to need health care.
3. State-of-the-art patient information technology has enabled some health care providers to differentiate their care. The provision of fast information about health care concerns is valued by patients.
4. Standardized care plans can improve the quality and decrease the cost of care.

5. Tennessee has a stable economy.

External Threats

1. Continuous change in reimbursement methods and governmental regulations leads to decreased revenues and increased administrative costs.
2. Competition from other hospitals, especially in the West Tennessee market.
3. Impact of TennCare reform.
4. Nursing shortage.
5. Costs of high tech, high quality care.

STRATEGIC ALTERNATIVES

Adaptive Strategies

1. Divestiture – exit clinics in Mississippi market.
2. Retrenchment/Divestiture – divest West Tennessee division to fund growth.
3. Enhancement – achieve academic medical center status for Methodist University Hospital.
4. Expansion – Buy other facilities or align with others to increase market share and service area.

Market Entry Strategies

1. Alliance – Develop a network with the Regional Medical Center at Memphis, the Veterans Administration, and the University of Tennessee Health Sciences Center to develop Methodist University Hospital as an academic medical center.
2. Acquisition – Purchase University of Tennessee Bowld Hospital and develop transplant program as part of Methodist University's core services.
3. Internal Development – Enhance educational opportunities provided by MELI for Methodist associates and health care professionals.

Competitive Strategies

1. Differentiation – Develop Methodist University Hospital as a state-of-the art academic medical center.
2. Focus: Cost Leadership – Emphasize cost leadership throughout the organization through standardized and uniform practices.

Value Adding Support Strategies

1. Build a culture of collaboration, accountability and dependability, streamline structure, and upgrade technology (information systems).
2. Communicate mission, vision, values, and goals to customers.

QUESTIONS FOR CLASS DISCUSSION

1. What are the most important environmental factors that Methodist Healthcare should incorporate into its strategic planning effort?

Methodist Healthcare was faced with several environmental factors that needed to be considered during their strategic planning effort. First, there was an overall decline in health care reimbursement that required Methodist to analyze costs system-wide. Federal programs in addition to the state-run TennCare program were announcing program and reimbursement cuts on a regular basis. Business lines were evaluated based on their contribution to financial performance and mission. Students should be encouraged to review Exhibit 2/13 and determine whether business lines with financials losses were essential to the organization's mission.

Secondly, there was a nationwide shortage of nurses, and although Methodist Healthcare invested in significant recruitment efforts to hire highly skilled nurses, the shortage along with the competition's recruitment efforts limited Methodist Healthcare's ability to recruit and retain nursing staff.

Managed care positioning was a significant variable in the external environment. Although Methodist Memphis' market share had reached 43.9 percent in 2001, well-established physician relationships and referral trends in the West Tennessee Market were contributing to West Tennessee's increasing financial losses.

2. Develop a list of critical success factors for Methodist Healthcare and discuss the rationale behind them.

Students can be asked to develop a list of critical success factors based on the situational analysis, the new vision statement, and the goals developed to assist in accomplishing the new vision. The critical success factors may include the following:

a. Remain #1 in Memphis market share – Methodist Healthcare remained focused on Methodist Memphis and relinquishing market share was not an alternative.
b. Be a leader in quality health care – Methodist Healthcare launched major Care Transformation initiatives and focused on improving patient care processes system-wide.
c. Implement new technology – The installation of Cerner technology was instrumental to the success of the quality initiatives.
d. Focus on Associates – Having the right people in the right place was key to Methodist's future success.
e. Become an A-rated company by the investment community – To achieve technological and service enhancements, Methodist Healthcare had to be financially strong.
f. Commitment to leader and associate development – Continue the focus on attracting and retaining great associates as well as investing in their education. It was critical for Methodist Healthcare.

3. What are the strategic objectives for Methodist Healthcare? Discuss the various strategic alternatives available to Methodist Healthcare to fulfill its objectives.

The strategic objectives are developed from the critical success factors. For each objective, strategic alternatives are considered to develop appropriate strategies. The key

idea behind this process is to foster strategic thinking among students. The students should be encouraged to review each critical success factor and discuss alternatives toward achieving its goals. This is an opportunity to utilize "role playing" by having students assume the role of one of the executive positions outlined in Exhibit 2/1.

4. Discuss the importance of communicating Methodist Healthcare's vision to its customers.

Communication is essential to the success of any strategic initiative. Methodist Healthcare implemented an aggressive plan to communicate to its key stakeholders the new vision of the organization. Methodist had to achieve "buy-in" from its physicians, leaders, and associates to accomplish its vision.

5. What is Methodist Healthcare's financial condition? Has it been improving or deteriorating in recent years?

Methodist Healthcare's financial condition had been improving over the past several years; however, the West Tennessee Market and the Mississippi Clinics were continuing to run at a deficit. An overall decision of where to invest Methodist's capital had to be made. Should Methodist continue to fund business lines that are losing financially, the organization will not be able to focus its attention on business lines that are contributing to the organization.

6. What is your recommendation for Methodist Healthcare to maintain its strategic momentum?

The students should answer the questions posed by Mr. Shorb to his leadership team. The questions encompass each of the strategic alternatives discussed under that heading.

EPILOGUE

By January 2005, Methodist Healthcare had celebrated many accomplishments including:

a. The continuation of its Care Transformation initiatives, especially the installation of Cerner technology and a system-wide focus on quality improvement;
b. Measurable improvement in overall patient satisfaction scores with a higher percentage of patients rating their care as "excellent;"
c. The sale of its West Tennessee hospitals to Community Health Systems, a company that is committed to making significant improvements in the hospitals;
d. The sale of the Mississippi-based clinics to Tunica County involving a transition of ownership mid-year;
e. The UT Bowld Hospital moved to University Hospital to continue to strengthen transplant and chronic disease programs;
f. Methodist Healthcare achieved a net income of $42.5 million in 2004 and became an A-rated company;

g. A continued focus on attracting and retaining great associates, reflected in higher scores in the Associated Feedback Survey and reduced voluntary associate turnover.

Although Methodist Healthcare's mission remained the same: "Methodist Healthcare, in partnership with its medical staffs, will be the leader in providing high quality, cost effective healthcare to benefit the communities we serve. Services will be provided in a manner that supports the health ministries and *Social Principles* of The United Methodist Church," the vision statement was refined to better align the vision with the mission of the organization, as follows:

> *Methodist Healthcare is a faith-based healthcare system that in partnership with its physicians will be nationally recognized for delivering outstanding care to each patient.*

Refinement of the vision statement allowed Methodist Healthcare to better apply its mission to business decisions to provide access to care for all payors, support education and research, serve the entire community, and balance all of the above with being good stewards of its financial resources.

Methodist Healthcare, in addition to "Service, Quality, and Integrity" added "Teamwork" to its values, asserting its commitment to fostering a culture of collaboration, accountability, and dependability with a strong commitment to diversity.

Methodist Healthcare continues to pursue excellence in clinical quality, service, and financial performance. Through "The Power of One – One Team. One Vision. Better and stronger because of You," teamwork is continuously emphasized for associates to work together to achieve Methodist Healthcare's goals for the future.

CASE 3

Community Blood Center of the Carolinas: Donations, Donations, Donations

OVERVIEW

In 2002, Tom Hassett, group Vice-President for Carolinas Healthcare System, was responsible for studying the laboratory service line. He discovered that blood costs were increasing more rapidly than others. In just one year, the cost for blood had doubled. Most hospitals in the area were experiencing the same situation. Discussions with the Red Cross (the dominant supplier of blood in the area) went nowhere. Other hospitals called to express their interest in looking at an alternative to the Red Cross. The Community Blood Center of the Carolinas (CBCC), the first community blood center in North Carolina, emerged as a result of the effort by ten Charlotte-area hospitals. It was the first time that there had been such extensive collaboration to resolve a common problem – the rising cost of blood.

CBCC faced some difficulty in blood collections, a key success factor. The mission of CBCC was to make sure that the blood donated in the area would stay in the area to help family members, friends, and neighbors. For years, the American Red Cross had drives in the region sponsored by the major corporations, government entities, and churches – it was really entrenched. Collecting blood was nearly identical no matter whether it was the Red Cross or a community blood center because the process was so heavily regulated by the FDA. The major differences were in donor satisfaction and sponsor satisfaction.

CBCC urgently needed to expand the number of donors and sponsors, increase its cash flow, and increase the level of customer/donor/sponsor service to survive. Was it possible before the organization ran out of funds?

KEY ISSUES

1. Competing against a well entrenched, well funded, and well recognized organization in the industry – a real Goliath.
2. Developing challenger strategies.
3. Differentiating a nearly identical service.
4. Surviving with weak cash flow and "shallow pockets."
5. Building awareness for a new, cash-poor organization.
6. Making decisions about product/market scope when the organization faces many challenges.

TEACHING OBJECTIVES

After analyzing this case, the student should be able to:

This teaching note was written by Linda E. Swayne, The University of North Carolina at Charlotte. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

1. Analyze a projected budget that is overly optimistic and attempt to find ways to bring reality to the organization.
2. Understand the importance of strategic planning and marketing for a small, not-for-profit organization.
3. Develop feasible strategic alternatives in difficult circumstances.
4. Develop a plan to differentiate a service.

SWOT ANALYSIS

Community Blood Center of the Carolinas faces the following internal strengths and weaknesses and external opportunities and threats:

Internal Strengths

- CBCC is focused on serving the needs of blood donors, patients, and health care providers in the Charlotte region.
- CBCC exceeded requirements on all factors for the annual FDA inspections meeting the high quality standards the organization set for itself.
- Ten Charlotte-area hospitals committed to work together to develop and support a community-based blood organization.
- Doctors could get blood products to best meet the needs of their patients.
- High level of donor and sponsor satisfaction.
- CBCC charged hospitals $150 per unit of blood (the Red Cross charged $200 per unit).
- CBCC board members included medical experts and business leaders.
- CBCC is a member of American's Blood Centers (ABC) and the American Association of Blood Banks (AABB).
- Additional blood can be purchased from other ABC blood banks to fill the area hospital needs while CBCC redoubles its efforts to increase collections.
- CBCC provided donors with a choice of where they gave blood.

Internal Weaknesses

- Blood collections in 2003 were one-half of the projected amounts (700 units collected vs. 1,400 projected).
- Initial and 2003 CBCC costs were significantly higher than budgeted or anticipated.
- CBCC may run out of cash by September 2004.
- Very little awareness of CBCC in the community.
- Miscalculation of the challenges in recruiting sponsors and donors.
- High costs: leasing a huge facility, leasing of two apheresis machines, more than needed specialized employees hired, and so on.
- Because of high costs and cash-flow problems, the Board deleted the marketing budget.
- Specialized staff was not being kept busy (not working 40 hours per week); their skills were in high demand and they could leave and be hired elsewhere.
- Staff reduction from 50 to 31.
- Management turnover in leadership positions since CBCC's inception.
- No long-term strategy.

External Opportunities

- Carolina's region is very strong in donating blood (led the nation from 1997 to 2003).
- More than 1.5 million people in the region – 900,000 potential donors.
- Healthy persons were able to donate blood every 56 days or six times per year.
- Blood donations by seniors (over 65) acknowledged as safe and practical.
- Demand for lower cost blood supply.
- Red Cross problems: safety with the blood supply; negative publicity after September 11, 2001 and discarding of blood; hospitals were unhappy with Red Cross monopolist attitude; failed FDA inspections and fines.

External Threats

- Only 5 percent of the US population donates blood; 60 percent could donate.
- An increase in the number of screening tests (AIDS/HIV, SARS, West Nile, and so on) decreases the number of eligible donors.
- The Red Cross, an international organization with a strong reputation, is entrenched with donors and sponsors, especially large businesses and government organizations (police, fire fighters, military).
- Red Cross improved pricing/service to squelch competition.
- Bad press garnered by the Red Cross related to September 11, 2001 errors carrying over to all blood collection programs.
- Artificial blood substitutes.

ALTERNATIVE STRATEGIES

Contraction/Retrenchment – CBCC has already undergone retrenchment with labor reduction and marketing budget cancellation. Neither was very effective.

Contraction/Divestiture/Liquidation – Divest to the Red Cross or liquidate the equipment to other community blood centers.

Maintenance of Scope/Status Quo – Not possible. CBCC will have to close as it is losing a great deal of money each month.

Maintenance of Scope/Penetration – Required for survival. Induce more people to donate blood through CBCC (the cash flow problems will be aided by an increase in blood collections).

Expansion/Market Entry/Alliance – Collaborate with hospitals in other areas of North and South Carolina to do blood processing for them.

Positioning Strategy/Focus Differentiation – Charlotte region is targeted with better quality (as evidenced by the superior FDA inspections), as well as better service to donors and sponsors.

QUESTIONS FOR CLASS DISCUSSION

1. From the SWOT analysis, in what quadrant does CBCC fall?

Survival. CBCC has many significant weaknesses and a major threat in the Red Cross. The survival quadrant strategies include: unrelated diversification, divestiture, liquidation, harvesting, and retrenchment. Diversification is not an option as the creators/supporters of CBCC have a specific need for blood; without blood products, there is no need for CBCC. Neither is harvesting an alternative because nothing has been established from which it can harvest (see the alternatives section of this IM for possible alternative strategies).

2. What insight does a stakeholder analysis reveal for CBCC?

Stakeholders for CBCC include:

- Blood donors (5 percent of the population),
- Potential donors (60 percent of the population),
- Sponsoring organizations that hold blood drives,
- Blood recipients,
- Area hospitals that formed CBCC,
- Health care professionals (particularly physicians who determine the type blood required for their patients – whole blood, leuko-reduced, platelets, etc.),
- Food and Drug Administration (FDA regulates blood collection),
- Federal government (oversight of the FDA and responsible for Medicare/Medicaid),
- State governments (Medicaid),
- Family, friends, and neighbors (the community),
- Employees of CBCC.

A stakeholder analysis appears favorable for CBCC because the area hospitals (and the physicians who work in them) are so highly invested in its success. With a significant marketing budget, CBCC's message could be heard by donors, sponsors, and recipients: blood collected in the region goes to patients in the region.

3. What are the key factors for success in blood banking? For CBCC?

Blood safety, service, the number of units of blood collected, increasing the number of new donors, and having repeat donors repeating more often are the fundamental success factors. Blood safety has to do with policies and procedures adopted and followed by the blood bank. The FDA approves the policies and procedures and then inspects regularly to make certain that the blood bank is following its own procedures and policies. The FDA has found the Red Cross to be in violation a number of times – so much in fact that the FDA went to court to gain approval for levying fines (and won the right to do so). The Canadian Red Cross no longer collects blood because of repeated violations (May 2005).

Service is to donors and blood drive sponsors. Both have to feel extremely satisfied that excellent service was delivered or they just do not make the time to donate or sponsor again. Attracting new donors is far more difficult than many people realize. More than 1.5 million people live in the region and 60 percent of them are able to donate blood. Because only about 5 percent of the population actually does donate, there are 925,000

new customers for CBCC in the area. Of the 5 percent who do donate blood (about 75,000 people), most could donate more often than they do, so there is a good market for repeat donations as well.

The key success factor for CBCC is to increase the number of donations. Through more units collected, CBCC will have product to sell to the hospitals. The hospital demand is greater than what CBCC can supply at this time. With increased revenues, the cash flow issue can at least be minimized. Increased donations require that at least some funds be expended on marketing. CBCC has a good service to market: the blood given by area donors would stay in the community to help family members, friends, and neighbors in the community.

In addition, CBCC had to deal with these issues on an urgent basis to maintain the organization's survival:

- Increase cash flow (CBCC was in danger of totally running out of cash in just a few more months).
- Increase the number of sponsors. Without donors, there is no product to sell to the hospitals. Few donors (very few) find their way to the CBCC facility; therefore sponsors are required to increase the number of donors.
- Increase the number of donors and the number of donations that they make.
- Build the CBCC brand. Develop awareness of CBCC and its mission in the community.

4. What are the cost factors that determine the price of blood?

There are a number of costs incurred by a blood collection organization such as CBCC. They include:

- Attracting sponsors and donors (advertising, sales, incentives);
- Collection of blood (employees to draw blood plus other staff, blood testing, blood collecting supplies such as needles, bags, identifier tags, bandages, etc.);
- Facility for collection, processing, and storing;
- Equipment for collecting, processing, testing, tracking, and storing blood;
- Blood transportation to sites where it will be transfused to patients;
- Licensing/processing fees owed to Virginia Blood Services;
- Pursuit of FDA licensing;
- Donor and sponsor retention.

Some of the costs above are out of line for CBCC. Its facility was leased for seven years and is far too big (including volume that adds to the cost of maintaining temperatures required by blood – the HVAC system). CBCC was drawing and processing less than half of Greg Ball's original forecast for units collected. Leasing two apherisis machines at a cost of $4,000 each per month when one machine is not kept busy was too expensive for the fledgling operation. The elimination of the marketing budget by the board was seen as necessary because CBCC was blowing through its line of credit and was going to run out of money; however, without attracting sponsors and donors, there is no need for the facility, equipment, or employees. A minimal budget for marketing was finally re-instated.

5. What can CBCC do to increase blood donations?

Basically, people are more concerned about their family, friends, and neighbors than strangers in other areas – especially when they are aware of a specific local need. Consequently, because CBCC is so closely involved with the area hospitals, it can access "great stories" and build the donor and sponsor base.

Increase the level of customer service. CBCC needs to be talked about in the community. If people are delighted with their CBCC experience they will tell some of their family, friends, and neighbors. Eventually superior service will have an impact. Although this will be slow to "spin the flywheel" superior service doesn't take extra dollars (such as advertising), only extra effort on the part of all employees.

Increase hospital support (non-financial) to assist CBCC in collections. For example, hospital visitors who have nothing to do but worry over a loved one may be persuaded to donate blood to help others in the hospital.

Increase penetration in the area through: more education about giving blood; more "stories" about life saving blood donations; statistics on how many lives are saved each day by local people donating blood; making blood donation a fun, pleasant experience; and going beyond building awareness of CBCC to building preference and insistence to donate at a CBCC site.

Providing information about blood donation to first-time donors is an important educational goal for the community. Some people are not familiar with the blood collecting processes and they are afraid to donate. If CBCC provides more education and is easily reached and responsive when people have questions, a new donor may be converted to a life-time donor.

Provide more information and detail concerning the importance of donation. CBCC should provide more statistics about the lives saved through the gift of blood donation.

Contact donors frequently. A birthday card sent to say "You're having one – make a gift of blood to give someone else another birthday." Contacts should not always ask for a donation, but build the relationship. Cards or emails signed by the collecting team after the donation could make people feel appreciated. This makes the donor think of CBCC when they would like to make a donation.

Promotions work in some markets to entice the first time donor and repeat donors appreciate a thoughtful gesture. Offer a gift after the donation, such as a t-shirt, pen, or pin all of which should promote CBCC and use its logo. Arrange a "thank you" event for donors.

Seek pro bono work (donated work) by an ad agency to develop public service announcements (PSAs) that will grab attention (they have to be excellent or they will never be placed since stations are no longer required to do PSAs). Have a local university

provide a Marketing plan (College of Business) and a PR plan (Department of Communications).

Work with local companies to see if there is a possibility of the companies offering incentives to their employees to donate on the job, such as vacation time or flex time, would prompt many new donors to come forward. (A concern is that some people cannot donate although they appear healthy and they might believe they are discriminated against – they can't earn the extra vacation time because they cannot give).

6. What segments in the population should CBCC target to increase blood collections?

CBCC has three choices in targeting donors: new, first-time donors who are less knowledgeable about the Red Cross, current Red Cross donors, and affiliates of the organizations that came together to form CBCC (employees of the ten area hospitals and their friends and families). Targeting first-time donors is challenging because they are typically misinformed and fearful (60 percent of the population can donate blood, but only 5 percent does). Targeting current Red Cross donors represents a head-on, frontal attack and is not recommended. Retaliation may be swift! The ten area hospitals are an excellent target and the first to be pursued by CBCC. Unfortunately, most of these employees are females and many of them are in child bearing years, resulting in a higher percentage of deferrals (not able to donate on a specific date because of low hemoglobin, under 100 pounds, and so on) than is seen in the general population.

High school students (typically seniors because the minimum age to donate blood is 17) are a group that CBCC could target because they may become lifetime donors. With high school students, if it is "cool" many will overcome their fear to participate and be part of the crowd. The chief advantage of this group is that they are less likely to be entrenched with the Red Cross for blood donations. Thus, it is easier to communicate and build relationships with them. Partnering with companies that target late teens and 20-somethings, such as clothing stores, restaurants, entertainment venues, to have a discount program (10 percent off coupon with a donation) that escalates with more donations (50 percent off with four contributions in a year, for example), offers incentives for the donors and benefits the "partners" as well.

Targeting the seven college campuses in the area may reach additional first time donors although this group may not be as viable an alternative as some might think because the students are often not eligible to donate – they're run-down and sick, they have just had body piercing or tattoos, and they are busy with class/work/parties. Another possibility is to partner with fraternities and sororities on campus, especially if a friendly competition can be started. However, the Red Cross is supported by some fraternities and it may be a national tie that the local chapter cannot control.

Senior citizens that are healthy and capable of donating blood often have more time and would enjoy the socializing as they donate blood. Until recently, age was used as a factor to determine eligibility. Thus, new communications have to be directed to seniors to inform them of their eligibility to donate. In addition, those who have donated in the past

may be loyal to the Red Cross because it was the only blood collection agency in the area for so many years.

7. How can CBCC differentiate its services?

The Red Cross is really entrenched in the area. For years, it has had drives at companies, government entities such as the police and firefighters, and churches. The largest companies and governments in the region (where collections can be most efficient) had a long history of sponsorship with Red Cross. Second, collecting blood is nearly identical no matter whether it is the Red Cross or a community blood center because the process is so heavily regulated by the FDA. The only one difference would be seen in donor satisfaction and sponsor satisfaction.

Customer service plays a critical role in building the donor and sponsor base. CBCC must always provide superior service by hiring and training every employee to be dedicated to delighting the customer. Rather than simply aiming for customer satisfaction, CBCC must be committed to customer loyalty – a much higher level of satisfaction and more difficult to achieve. All employees must be professional, cheerful, and appreciative of the donor's commitment to giving blood.

Because the Red Cross cannot resolve some of its blood products safety problems, the FDA sued for a revised consent decree and received it. When the Red Cross does not follow its own safety procedures (that have been approved by the FDA), the FDA will fine the Red Cross. The situation enables CBCC to capitalize on its higher standards of quality and its recent inspections that surpassed FDA requirements.

8. What should CBCC do immediately?

Extend their marketing budget and efforts to increase the awareness of CBCC in the area. Work with the hospitals. Target minor media (lower cost) that are highly community focused.

Increase the number of blood drives each year with existing sponsors. The best customers are those who are already customers. Increase repeat business.

Benchmarks should be established for repeat donors, striving for 50 percent repeat donors. For those who have given once, fifty percent should give again during the year. For those who have given more than once, efforts should be made so that fifty percent of that group donates blood the maximum number of times (six times per year).

If the organization cannot meet its financial obligations it should consider closing operations by selling to the Red Cross or liquidate by selling equipment to another community blood center.

EPILOGUE

The new executive director, Martin Grable, is a visionary leader who is also a good manager and works hard. He has great passion for blood donations for the community.

He found that CBCC was supplying 85 percent of the blood to eleven hospitals (one new hospital in the Presbyterian organization recently opened) through one blood center – CBCC. This message 85 – 11 – 1 is causing many individuals and organizations to take notice of CBCC – including the Red Cross. The regional Red Cross director has made an offer to buy CBCC. April 2005 was the first month that CBCC did not experience a loss.

CASE 4

ASPIRE^2 in Arkansas

OVERVIEW

In 1995, members of the senior staff and the health officer of the Arkansas Department of Health (ADH) were increasingly concerned about changes taking place in public health nationally and within the state. The programs at professional meetings were packed with public health experts warning of the dire consequences of managed care and increasingly aggressive competition from the private health sector. The news media bombarded all public agencies with legislative demands for accountability.

In July 1996, the Arkansas Department of Health initiated a comprehensive strategic thinking process known as ASPIRE (Arkansas Strategic Planning Initiative for Results and Excellence). The formal planning process required a year to complete, but ASPIRE continued in Arkansas because strategic thinking became a way to lead this large and complex organization. During the time of the initiative, the governor of the state changed, the health officer changed, and public health in Arkansas struggled with limited resources and higher standards of accountability. The Department's commitment was based on the dedication of the leaders and employees to put the public health of Arkansas above personal agendas, make difficult decisions, respect the dignity of individuals adversely affected by change, and provide the most secure environment possible in turbulent times.

Dr. Fay Boozman was appointed director for the Arkansas Department of Health in February 1999. When Dr. Boozman was named, the usual amount of uncertainty arose among the employees because it was unclear what his view would be regarding ASPIRE. However, Dr. Boozman endorsed ASPIRE, complimented the vision it created, and committed himself to reenergizing the strategic management process.

In May 1999, a comprehensive review session was conducted, at which time Dr. Boozman left no doubt about his commitment to change public health in Arkansas and his commitment to strategic management in general and ASPIRE in particular. In open letters to colleagues and in his public statements, Dr. Boozman continued to emphasize his commitment to "absolutely change the way we do public health by removing barriers to excellence." The reenergized initiative became known within the Department as ASPIRE^2. Dr. Boozman wanted to strengthen the focus on improving customer and colleague satisfaction and more effectively use Department resources.

Colleagues of the ADH completed situational analysis (external environment; internal environment; and mission, vision, and values). The strategic planning steering committee needed to make some critical decisions. Expectations were high for the Steering Committee to finalize

This teaching note was written by Peter M. Ginter and W. Jack Duncan, University of Alabama at Birmingham, and Linda E. Swayne, The University of North Carolina at Charlotte. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from Pete Ginter.

the work that had been done and to develop strategic goals for ADH. Members of the Steering Committee knew that their decisions would set the future course of ADH.

KEY ISSUES

1. Strategic management in a rapidly changing health care environment.
2. Instituting strategic management in a decentralized, not-for-profit organization.
3. Achieving strategic focus in an organization with a broad portfolio of services and activities, all of which are important.
4. Deciding the nature of public health in light of limited financial and human resources.
5. Methods for thinking strategically and prioritizing public health programs.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Demonstrate the applicability of strategic management in public health organizations.
2. Realize that strategic momentum is ongoing and that strategic management is not a one-time endeavor.
3. Discuss ways that an organization might set goals, prioritize programs, and reallocate resources using situation analysis as background information.
4. Understand that there is no "calm" time to plan.
5. Assume a decision-making role regarding the development of strategies and implementation plans.

SUGGESTIONS FOR EFFECTIVE TEACHING

Users of the fourth edition of this text will recognize much of this material as being from Chapter 12, "Inventing the Future through Strategic Thinking: An Example." This case may be used as an illustrative example of the strategic management process as it happened at the Arkansas Department of Health. The results are those actually produced by the ADH personnel. The case is an excellent summary of situational analysis and the strategic thinking process.

In teaching this case we usually ask students if they have had any experience in strategic planning. Often students have been involved in some manner. We ask them to describe the process their organization used to carry out strategic planning and compare it with the process presented in the text. We typically ask the students to comment on the usefulness of the methods presented in the text to stimulate strategic thinking.

In discussing the case, we emphasize that what the health department *should* be doing is determined by its external environment (community, state, and national issues). What the department *can* do is determined by its strengths and weaknesses. It is the combination of external issues and internal strengths and weaknesses that will determine the appropriate mission, vision, and strategy for the Department (what it *wants* to do). Therefore, it is useful to break the class into external issues and internal strengths/weaknesses groups to lead the

discussion. After thoroughly discussing the external issues and internal strengths and weaknesses, the instructor should ask the class, "Where do we go from here?" Some students may indicate that the strategic plan is completed. They may need to be "encouraged" to work through implementation. After discussing how implementation may vary from for-profit to not-for-profit, private and public, large and small organizations, students should come to the conclusion that implementation must be uniquely applied to public health organizations as well. The collection of programs offered is the "product" and when directional and adaptive strategies have been determined, the important question, "What is the appropriate portfolio of programs?" must be answered. Ask the students which of the strategic thinking maps works best for determining the appropriate portfolio. Then ask, "Are the methods they used to prioritize their programs appropriate?"

A speaker from the public health department in your state could be invited to listen to the discussion and provide information particular to your state's situation.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS
A summary of the Arkansas Department of Health's internal strengths and weaknesses and external opportunities and threats is provided in the Case study.

STRATEGIC ALTERNATIVES

1. Enhancement/alliances and joint ventures/analyzer/focus differentiation – cooperation strategies with private health care organizations and counties.
2. Enhancement/quality – improving public health programs.
3. Product development/internal development – in core public health areas.
4. Defender – core public health.

QUESTIONS FOR CLASS DISCUSSION

1. What are the most important environmental factors that Arkansas Department of Health should incorporate into its strategic planning effort?

The external task force identified a number of major stakeholders that were considered central to the department's mission. The students should be encouraged to discuss the nature of these stakeholders, their relationship with ADH, and how they are related to the mission of the department.

In addition to stakeholder analysis, the task force summarized several trends and issues. Students should be encouraged to discuss and rank the issues/trends according to their importance. The idea behind this exercise is to help students understand that tracking all the issues may be too difficult to incorporate into the decision making process. Once the high significance issues/trends are identified, students can discuss the opportunities and threats for these issues.

2. Discuss the development process of the mission and vision statements of the ADH.

Different components of the mission and vision statements are given in the case. Students should be encouraged to discuss the process adopted by the task force to develop mission and vision statements for the ADH. If the students had participated in the process, what would they change about the mission and vision? Certainly the length of each should be discussed.

3. What should be the goals of ADH?

Illustrative List of Strategic Goals

Communication: The Department will evaluate and improve current communication methods to ensure the Department fosters open, two-way communication – employees will receive the information necessary to do their jobs in a timely and appropriate manner and are encouraged to share new ideas and problems with management.

Financial Resources and Stewardship

1. The Department will develop an accounting method that determines costs of programs and functional areas.
2. The Department will evaluate and improve financial management policies, procedures, and systems to ensure reliable accounting information, compliance with laws and regulations, and effective management of public funds.

Human Resources

1. The Department will implement a comprehensive orientation program for all employees.
2. The Department will offer employees opportunities for job-appropriate training and monitor participation.

Information, Equipment, and Technology: The Department will evaluate the needs, resources, and trends in information systems and establish a direction for the agency.

Organizational Structure and Responsiveness: The Department will review the current organizational structure and make changes needed to support the mission of ADH and contribute to key performance areas.

Public Image: The Department will be proactive in educating the public on the effects and benefits of public health services.

Community Health Assessment: The Department will develop the capacity/resources for training, information systems, and technical expertise to assist communities in local public health needs assessment.

Service Delivery: The Department will assess the need for and ability to participate in the managed care environment as a provider.

Ensure Compliance with Public Health Laws and Regulations: The Department will evaluate current public health rules and regulations to identify those that are outdated, those that are more appropriately administered by another agency, and those that do not address public health issues.

4. Can the methods used at ADH work for your state health department?

The strategic management process used at ADH should work well in most public health organizations. Organizations engaging in strategic planning will have to identify external opportunities and threats, internal strengths and weaknesses, and develop a mission, vision, values, and goals. Further, a strategy must be developed that accounts for the diversity and range of public health programs. Therefore, it would appear that program evaluation and prioritization would be a good starting point. However, managers (students) must always make a method or approach work for them, not work for the method. When working through a process, if a method or approach is not contributing to greater understanding, then it should be modified to better serve the organization's needs or abandoned in favor of an approach that does contribute to improved effectiveness in reaching a decision.

5. The Steering Committee of the ADH adopted strategic approaches to "facilitate strategic thinking within the Agency." What do you think is meant by the term "strategic thinking?"

Strategic management is an attitude – a way of thinking – that is an intellectual process. Strategic management requires a broad base of leadership throughout the organization and asks everyone to think as leaders. In a strategic context this process is called strategic thinking. Vision and a sense of the future are an inherent part of strategic management. Strategic thinkers are constantly reinventing the future – creating windows on the world of tomorrow. Strategic thinkers draw on the past, understand the present, and can envision a better future.

Strategic thinking, therefore, is an important foundation of strategic management. The rationale underlying strategic thinking is that what was appropriate and worked in the past is not necessarily appropriate or what will work in the future. It is important to understand the external issues (what we *should* be doing), the internal strengths and weaknesses (what we *can* do), and mission and vision (what we *want* to do) and prioritize what the agency will be doing in the future. Limited resources often force priorities (we cannot be everything to everyone). Thus, strategic thinking is about making the hard choices of what programs are most important to the external environment, internal agency capabilities, and mission.

EPILOGUE

After a great deal of discussion and investigation of organizational structure alternatives, the Leadership Team proposed a new decentralized organizational structure. The underlying philosophy of the new structure was composed of four interrelated aspects. These were (1) team management, (2) decentralized decision making, (3) unity of supervision, and (4) minimization of hierarchy.

The entire Department was conceived of as a series of interrelated teams – the Agency Leadership Team, regional teams, and functional teams. There were essentially three levels of interrelationship and the unity of supervision was clear. These two elements combined to simplify two-way communication and decentralize decision making.

In addition to the continued culture change and organizational initiatives, the ADH continued and expanded its commitment to Hometown Health Improvement – a community based health initiative. Clearly, the movement to community-based health was consistent with the philosophy of ASPIRE and ASPIRE^2 and the pace of Hometown Health Improvement was greatly accelerated by the Director. By the end of 2000, HHI had expanded from the pilot project in Boone County to 16 other communities around the State.

A strategic plan brings together the entire process into a single document that provides a quick reference and serves as a guide for decision making. The ADH strategic plan was summarized in a four-page brochure that could easily be circulated to audiences inside and outside the agency. It included statements of mission, vision, guiding principles, critical success factors, key performance areas, statements of strategy, and strategic goals.

Dr. Boozman, in open letters to colleagues and in public statements, continued to emphasize his commitment to "absolutely change the way we do public health by removing barriers to excellence." The journey continues and ADH has become a strategically managed organization in less than five years. However, the transition required a great deal of hard work by leadership and faith in the future by employees to keep the strategic priorities in front of everyone to encourage strategic thinking. Although challenging, ADH has a better sense of what public health should be in Arkansas, has created clear momentum to achieve that vision, and is in the process of inventing a healthier future for all the citizens of Arkansas. Strategic management has helped ADH sharpen its focus, decide which services it wishes to perform and which ones it does not, and has resulted in some truly positive change in a relatively short time. Strategic management is working for ADH and for the people it serves.

The ADH strategic plan has not been put on the shelf and ignored. All employees recognize that they have a part to play in ADH accomplishing its mission and achieving its vision. ADH's strategic plan is a living document that is encouraging the entire organization to create its future.

As many of you are aware, on Saturday, March 19, 2005, Dr. Boozman died at the age of 58 in a tragic accident while working on his farm in Rogers, Arkansas. We believe that in some measure the ADH case serves as a tribute to Dr. Boozman as a caring, passionate, and thoughtful leader. Dr. Boozman understood leadership and he was visionary, compassionate, and achievement oriented – a real leader. Dr. Boozman will be missed by everyone he touched.