Chapter 3G

Major Strengths, Problems and Initiatives of CAHs: A Balanced Scorecard Perspective and an Exploration of Positioning Strategies

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Introduction

This chapter presents the results of the most recent effort focusing on the major strengths, problems and initiatives of critical access hospitals (CAHs). The results are presented in three sections:

- Major Strengths, Problems, and Initiatives
- Using the Balanced Scorecard Perspective to Assess Major Strengths, Problems, and Initiatives
- An Exploration of the Strategic Positioning of CAHs

As CAH administrators identify a wide range of major strengths, problems and initiatives, the Balanced Scorecard provides a useful framework for moving from viewing the major strengths, problems and initiatives individually, to viewing them in coherent groups. A Balanced Scorecard is designed to provide a comprehensive picture of organizational performance, making sure that the user looks beyond financial success to the other areas ultimately affecting viability. While strengths in a Balanced Scorecard area do not ensure long-term viability, major problems in these domains are indicators, at the least, of barriers that must eventually be overcome to achieve long-term viability. The Balanced Scorecard groupings used in this chapter are financial, community, services, staffing and infrastructure.

The major findings are:

1. Over two-thirds of the strengths cited by CAH administrators fall into the infrastructure and services areas of the Balanced Scorecard. Respondents overwhelmingly feel the quality of their services and staff and the way they are governed (the board and management team) are particularly strong. In addition, a large portion feel the community is quite supportive.

2. While infrastructure, services and community are seen as areas of major strength, the complementary areas, staffing (recruiting and retention) and finances, are seen as major problem areas. Respondents report financial problems in regard to both

Medicaid and other non-Medicare revenue sources. They also report major staffing problems in recruiting and retaining physicians and non-physician clinical staff. In addition, around 40 percent of the administrators report major problems involving modernizing facilities and access to capital.

3. Given these strengths and problems, it is interesting to note that the major initiatives CAH administrators most frequently say they are currently undertaking, or are likely to undertake in the next three years, are in a single area of the Balanced Scorecard: infrastructure. In particular, the modernization of facilities and equipment is the single most cited major initiative area. Of concern is that relatively few major initiatives are listed in the areas of recruiting and retaining physicians and non-physician clinical staff. This may be due to four reasons: CAH administrators were restricted to listing only three major initiatives; recruiting and retention activities may be so much a part of their everyday activities, they were just not listed as major activities; CAHs are not and do not plan to undertake any such initiatives in the next three years; and/or it is possible that improvement of infrastructure is a necessary first step toward recruiting staff.

4. Approximately 80 percent of CAH administrators reported that their facility had at least one major adaptive strategy.

Methodology

The primary sources of data for this chapter are the Year 2 and Year 3 telephone surveys conducted by the University of Minnesota (UM) on behalf of the Tracking Team. The Year 2 telephone survey of 217 CAH administrators is described in last year's report. The Year 3 telephone survey is described earlier in this report. Year 3 survey data are used in the first two sections of this chapter, which focuses on major strengths, problems and initiatives. The Year 2 data set is used as the basis of the strategic positioning analysis described in the last section of this chapter.

Regarding the major questions from the Year 3 telephone survey analyzed in this chapter, each of the 388 respondent was asked to identify major strengths and problems among 23 items grouped into four areas--*finance; services; staffing; and governance, administration, and infrastructure*. In addition, they were asked to rate their relationship with their *community* on a 1 (Not Supportive at All) to 5 (Extremely Supportive) scale. For readability, the term *infrastructure* is used throughout this report as shorthand for governance, administration and infrastructure. In addition to the questions regarding major strengths and problems, respondents could identify up to three major strategic initiatives they are currently undertaking, or intend to undertake, within the next three years.

The Balanced Scorecard groupings referred to in this chapter are financial, community, services, staffing and infrastructure. The five categories used in this survey were derived

from the four domains identified by Kaplan and Norton (1996), the originators of the Balanced Scorecard: finance, stakeholders, internal processes, and learning and growth. The major difference is that when applying the Balanced Scorecard to the hospital industry, staffing fits within both the internal process and learning and growth (infrastructure) areas used by Kaplan and Norton. We have not attempted to artificially place staffing into one or the other of these alternatives. As respondents identified major strategic initiatives in an open-ended format, responses were subsequently categorized into the five Balanced Scorecard categories used herein.

In addition to the analyses above, an exploration was undertaken to better understand the strategic positioning efforts of CAHs. Each hospital's strategic posture was characterized through a two-step process. First, all strategic initiatives from the 211 Year 2 respondents were classified into one of 11 adaptive strategies identified by Rowe et al. (1989) in an attempt to understand strategic positioning efforts of organizations: Harvesting, Status Quo, Divestiture, Liquidation, Retrenchment, Diversification, Integration, Product Development, Market Development, Penetration, and Enhancement. If a strategy could be placed into two categories, it was placed in the most conservative (least expansive) of the two. Next, the adaptive strategies were classified into four major categories descriptive of strategic posture: conservative, defensive, competitive and aggressive. The CAHs were placed in these categories based on their most aggressive adaptive strategy. The results are presented here as postures that are conservative/defensive or competitive/aggressive.

Findings

Major Strengths, Problems, and Initiatives — An Overview

This section reports on the perceptions by CAH administrators of the major strengths, problems and the initiatives they are undertaking to position their institution for the future. The next section further analyzes these initiatives from the point of view of the Balanced Scorecard. Numbers throughout the text, but not those in the tables, are rounded to the closest unit for readability.

Major Strengths

The CAH administrators interviewed in Year 3 exhibited a great deal of consensus regarding their hospitals' major strengths, with over three-quarters citing strengths in the areas of quality and infrastructure (Table 1). The average number of strengths cited was 10.9, with a median of 11.

With regard to quality, almost 90 percent of respondents cited quality of services and three-quarters rated their quality of staff as major areas of strengths (Table 1). With regard to infrastructure, four items were identified as major strengths by approximately

75 percent or more of the respondents: the management team, the board, network affiliation/support, and physician/hospital relations. Other areas noted as major strengths by over 50 percent of the CAH administrators were: number of outpatients, outpatient services, relationship with government and professional organizations, financial personnel/systems, and managing expenses. The major strengths of CAHs are examined more closely in the Balanced Scorecard section below.

Table 1. Top 10 Major Strengths of CAHs

	(%)*
Quality of Services	87.9
Management Team	84.0
Board	78.9
Quality of Staff	77.1
Network Affiliation/Support	74.5
Physician/Hospital Relations	74.2
Number of Outpatients	71.1
Outpatient Services	68.3
Relationship w/ Government and Professional Organizations	65.2
Financial Personnel/Systems	55.9
Managing Expenses	52.1

* *Percent of respondents citing item as a percent of all respondents (N = 388).*

Major Problems

The CAH administrators showed less agreement in identifying their hospitals' major problems than they did their major strengths. The only problem areas cited by more than 50 percent of the respondents were in the areas of staffing and revenues (Table 2). The average number of problems cited was 5.5, with a median of 5.

Other items cited by approximately 40 percent or more of the CAH administrators as major problems were the number of inpatients, modernizing facilities, and access to capital. Over a third indicated non-financial information systems as a major problem as well. The major problems of CAHs are examined more closely in the Balanced Scorecard section below.

Table 2. Top 10 Major Problem Areas of CAHs

	%*
Recruiting/Retaining Nurses for Current Services	55.9
Recruiting/Retaining Nurses for New Services	53.4
Medicaid	52.3
Other Revenues	52.3
Recruiting/Retaining Physicians for New Services	45.1
Number of Inpatients	44.3
Modernizing Facilities	42.0
Recruiting/Retaining Physicians for Current Services	41.5
Access to Capital	39.7
Non-Financial Information Systems	33.8

* *Percent of respondents citing item as a percent of all respondents (N = 388).*

Major Initiatives

Of the 388 hospital administrators interviewed, 229 identified at least one major initiative that they are now implementing or planning to undertake within the next three years. Seventy-eight respondents listed two initiatives and 37 listed three.

There is a great deal of diversity among the CAHs in the major initiatives that are being undertaken or are planned in the next three years. While over 45 percent of the initiatives are in the area of modernizing facilities, there are only four other areas in which at least 10 CAHs have an initiative: outpatient services, recruiting and retaining physicians and clinical staff, network affiliation and support, and access to capital (Table 3).

There were few initiatives identified by the respondents relating to improving two areas cited as major problems: Medicaid and other revenues, and recruiting and retaining physicians and non-physician clinical staff. Initiatives are discussed in more detail in the following sections of this chapter.

Table 3. CAHs' Major Initiative Areas

	%*
Modernizing Facilities	35.6
Outpatient Services	12.4
Recruiting and Retaining Physicians and Clinical Staff	10.1
Network Affiliation/Support	5.2
Access to Capital	2.6

* *Percent of respondents citing at least one initiative as a percent of all respondents (N = 388).*

Major Strengths, Problems, and Initiatives by Balanced Scorecard Area

While the preceding section furnished an overview of the major strengths, problems and strategic initiatives of CAHs in general, this section further analyzes each of these from the point of view of a Balanced Scorecard using the following domains: infrastructure, services, financial, staffing and community.

Major Strengths

Of the 388 responding CAH administrators, 387 cited at least one major strength, with an average of 10.9 and a median of 11. CAHs' strengths can be considered from two points of view. On the one hand, the *distribution of the major strengths by Balanced Scorecard category* helps answer the question: What do CAH administrators see as their institutions' major strengths? This is a useful measure because respondents cited multiple strengths within a particular category. On the other hand, the *distribution of respondents citing any particular strength within a Balanced Scorecard category* answers the question: How common are the particular strengths cited by CAH administrators? Table 4 provides a summary from both perspectives. Table 5 is then used to explore these findings in more depth and to look at the distribution of CAHs across individual items. Thus, it uses the number of CAHs, 388, as the denominator.

In looking at the distribution of major strengths, Table 4 shows that 40 percent of the strengths cited were in the area of infrastructure, followed by services, financial and staffing. In fact, infrastructure and services accounted for approximately two-thirds of the strengths cited by respondents.

Table 4. Major Areas of Strength Classified by Balanced Scorecard Category

	Number of Strengths	Percent of Strengths	Number of CAHs	Average Number of Strengths Per CAH
Infrastructure	1700	40.1	386	4.3
Services	1118	26.4	371	2.9
Financial	832	19.6	321	2.1
Staffing	589	13.9	322	1.5
Total	**4239**	**100.0**	**388***	

** Total equals the total number of hospital administrators responding to the survey (388).*

Infrastructure: An organization's infrastructure provides a foundation upon which other parts of the organization rest. It includes not only items related to governance (the board and management team) and facilities (plant and equipment), but also information systems and relationships (network affiliations/support and relationships with physicians, government and professional organizations).

Clearly, many of the CAH administrators see their major strengths in the infrastructure area of the Balanced Scorecard, citing an average of 4.3 major strengths in this area (Table 4). Within infrastructure, the management team, the board, network affiliation/support, physician/hospital relations, and relationship with government and professional organizations all were identified as major strengths by over two-thirds of the respondents (Table 5). Two related items, finance and staffing, are discussed separately in their own sections below.

Services: Twenty-six percent of the major strengths cited were in the services domain of the Balanced Scorecard, with an average of almost 3 per CAH (Table 4). The most frequently noted strength, both overall and in the services area, was the general quality of services. It was cited by 88 percent of respondents citing a major strength (Table 5). Notably, both items in the survey relating to outpatient services were also identified as areas of major strengths by over two-thirds of respondents, while the two inpatient items were cited by considerably fewer individuals (Table 5).

Financial: A far lower number of major strengths was identified in the financial area of the Balanced Scorecard than in infrastructure and services (Table 4). Only the items relating to financial personnel/systems and managing expenses were cited by over 50 percent of the CAH administrators as areas of major strength (Table 5). It is particularly encouraging to see financial personnel/systems rating so highly, as it may be an indicator of the development of a long-term financial infrastructure. While managing expenses was cited by over 50 percent of respondents, none of the three items relating to non-Medicare sources of revenue was cited as a major strength by over a third of the hospitals.

Staffing: As a percentage of all five areas of strength in the Balanced Scorecard, staffing rated quite low (Table 4). However, this masks a clear trend in the responses: over 75 percent of the CAH administrators rate the quality of their staff to be extremely high, but not their ability to recruit and retain them nor their physicians (Table 5). This raises a question regarding how long quality of services can be maintained if there is difficulty attracting and retaining clinical personnel.

Community: As discussed in the methodology section, this domain of the Balanced Scorecard was assessed in a different manner than the other domains. Twenty-seven percent of the respondents identified the community as extremely supportive and 71 percent rated community support as either extremely or very supportive, indicating that the community is a major area of strength.

Table 5. Most Frequently Listed Strengths by Balanced Scorecard Category

Infrastructure	%*
Management Team	84.0
Board	78.9
Network Affiliation/Support	74.5
Physician/Hospital Relations	74.2
Relationship w/ Government and Professional Organizations	65.2
Facilities	34.0
Non Financial Information Systems	27.3
Services	
Quality of Services	87.9
Number of Outpatients	71.1
Outpatient Services	68.3
Inpatient services	39.7
Number of Inpatients	21.1
Financial	
Personnel/Systems	55.9
Managing Expenses	52.1
Collections	43.0
Access to Capital	31.4
Medicaid	16.0
Other Revenues	16.0
Staffing	
Quality of Staff	77.1
Recruiting/Retaining Physicians for Current Services	27.1
Recruiting/Retaining Nurses for Current Services	19.6
Recruiting/Retaining Physicians for New Services	15.7
Recruiting/Retaining Nurses for New Services	12.4

** Percent of respondents citing item as a percent of all respondents (N = 388).*

Major Problems

Of the 388 responding CAH administrators, 370 cited at least one major problem, with an average of 5.98 and a median of 6. As with major strengths, CAHs' major problems can be viewed from two points of view. On the one hand, the *distribution of the major problems by Balanced Scorecard category* helps answer the question: What do CAH administrators see as their institution's major problems? This is a useful measure because respondents cited multiple problems within a particular category. On the other hand, the *distribution of respondents citing any particular problem within a Balanced Scorecard category* answers the question: How pervasive are the particular problems cited by CAH administrators? Table 6 provides a summary from both perspectives. Table 7 is then used to further explore these findings in more depth and look at the

distribution of CAHs across individual items. Thus, it uses the number of CAHs, 388, as the denominator.

Two-thirds of the major problems fell into the financial and staffing areas of the Balanced Scorecard, each represented about equally. Infrastructure and services each represented about 15 percent of the major problems cited (Table 6). It is important to note that if an item is not cited as a major strength, it does not necessarily appear below as a major problem and vice versa. It may, in fact, be neither a major strength nor a major problem.

Table 6. Major Problem Areas Classified by Balanced Scorecard Category

	Number of Problems	Percent of Problems	Number of CAHs	Average Number of Problems Per CAH
Financial	816	35.2	299	2.10
Staffing	781	33.7	304	2.01
Infrastructure	397	17.1	253	1.02
Services	326	14.1	210	0.84
Total	**2,320**	**100.0**	**388***	

** Total equals the total number of hospitals responding to the survey (388).*
*** Community data were collected in a different format, and this is discussed below.*

Financial: The four top-cited major problem items in the financial domain of the Balanced Scorecard all relate to revenues or collections. Three of these relate to gaining additional funds -- Medicaid, other revenues and access to capital. The item in this domain cited least often was managing expenses (Table 7).

Staffing: The staffing domain was the second most often cited area of the Balanced Scorecard, with all major problems involving recruiting and retaining physicians and non-physician clinical staff. Items related to recruiting and retaining nurses for both current and new services were cited as major problems by over half of the respondents, while items related to recruiting and retaining physicians for both current and new services were cited by at least 40 percent (Table 7). If these staffing problems continue, they not only indicate possible difficulties in the expansive initiatives noted below, but also in the ability of many CAHs to continue to provide services at the existing level of quality. The magnitude of the responses should add to the importance of the ongoing focus on health workforce issues in general and in rural areas in particular. Incidentally, these responses were gathered before recent actions were proposed to restrict the admission of foreign physicians to practice in the United States.

Infrastructure: Two items are of major concern in this area of the Balanced Scorecard: modernizing facilities and non-financial information systems. Modernizing facilities, both plant and equipment, was cited as a major problem by almost two-thirds of the CAH administrators, while non-financial information systems was cited by just over 50 percent (Table 7). It is not possible from the question to tell the particular capabilities of the

information systems that are problematic (i.e., human resources, medical records, purchasing, etc).

Services: Only one major problem emerges in the service area, inpatient admissions, which was cited by over 80 percent of the respondents. The remaining items related to inpatient and outpatient services are cited as major problems by approximately a quarter of the CAH administrators, and virtually none of the responding administrators cited quality of services as a major problem (Table 7).

Table 7. Rank Order of Major Problems within Each Balanced Scorecard Category

Financial	%*
Medicaid	52.3
Other Revenues	52.3
Access to Capital	39.7
Collections	29.4
Personnel/Systems	18.8
Managing Expenses	17.8
Staff	
Recruiting/Retaining Nurses for Current Services	55.9
Recruiting/Retaining Nurses for New Services	53.4
Recruiting/Retaining Physicians for New Services	45.1
Recruiting/Retaining Physicians for Current Services	41.5
Quality of Staff	5.4
Infrastructure	
Modernizing Facilities	64.4
Non-Financial Information Systems	51.8
Physician/Hospital Relations	15.4
Board	7.9
Network Affiliation/Support	7.5
Relations with Government and Professional Organizations	5.9
Management Team	4.0
Services	
Inpatient Admissions	81.9
Inpatient Services	25.7
Outpatient Visits	23.3
Outpatient Services	22.9
Quality of Services	1.4

** Percent of respondents citing an item as a percent of all CAHs (N=388).*

Community: As noted above, this domain of the Balanced Scorecard was assessed in a different manner than the other domains. Four percent of the CAH administrators identified the community as providing no or little support, indicating that relationship with the community is not a major problem area.

Major Initiatives

As noted earlier, each of the 388 respondents could list up to three major initiatives. Two hundred and twenty nine listed at least one initiative that they are now undertaking or planning to undertake within the next three years, with 78 listing two initiatives and 37 listing three. The distribution of initiatives among the Balanced Scorecard categories is far different than the distribution of major problems. While the financial and staffing areas accounted for two-thirds of the major problems (Table 6), they comprised less than a quarter of the major initiatives (Table 8). Almost 75 percent of the initiatives listed were in two areas of the Balanced Scorecard: infrastructure (57%) and services (20%). Relatively few fell into staffing (13%), financial (8%) or community (3%).

Table 8. Major Initiative Areas Classified by Balanced Scorecard Category

	Number of Initiatives	Percent of Initiatives	Number of CAHs	Average Number of Initiatives Per CAH
Infrastructure	188	56.8	170	0.5
Services	65	19.6	62	0.2
Staffing	41	12.4	41	0.1
Financial	27	8.2	27	0.1
Community	10	3.0	10	0.0
Total	**331**	**100.0**	**388***	

** Total equals the total number of hospital administrators responding to the survey (388).*

Table 9 identifies those initiatives cited by at least five percent of the CAH administrators. As can be seen from that table, only five initiatives met this criterion, though they are distributed among the Balanced Scorecard categories. The remainder of this section will explore these initiatives by Balanced Scorecard category.

Infrastructure: Forty-four percent of the respondents cited initiatives in the infrastructure domain (Table 8). As noted above, initiatives relating to modernization of plant and equipment dominated not only the infrastructure domain of the Balanced Scorecard, but also all initiatives (Table 3). This category is composed specifically of initiatives pertaining to the remodeling, renovation and building of new physical facilities. Examples of initiatives in this area include: “Building a new hospital to replace the hospital built in 1967;” “Looking at renovating patient’s rooms;” “Expanding the emergency department (more space);” and “Building a new addition for outpatient surgery lab.”

A related item, modernization of equipment, is discussed under the services category of the Balanced Scorecard. When modernization of facilities is combined with modernization of equipment, they comprise over 50 percent of the initiatives. It is not possible to tell how the conversion to cost-based reimbursement from the Medicare prospective payment system affected this decision. Though it would be interesting to examine the

relationship between financial status and capital initiatives, current audited data are not available for such an analysis. There is no observable relationship between the length of time since conversion and whether or not capital initiatives are being undertaken.

Table 9. Initiatives Classified by Balanced Scorecard Category

Infrastructure	Number of Respondents Citing an Item	Percent of Respondents Citing An Item*
Modernizing Facilities	138	35.6
Network Affiliation/Support	20	5.2
Services		
Outpatient Services	48	12.4
Financial		
Access to Capital	10	2.6
Staffing		
Recruiting and Retaining Clinical Staff	33	8.5

** Percent of respondents citing an item as a percent of all respondents (388). Only initiatives cited by at least 5% of the CAHs are shown.*

Services: Items relating to services comprised the second most frequently cited initiative area of the Balanced Scorecard (Table 8). Within this area, the dominant area was clearly outpatient services, which was cited by 12 percent of respondents (Table 10). Within outpatient services, the major initiatives fell into two interrelated areas: expanding services and modernizing equipment. Examples of expanding services include: "Expanded urgent care services;" "Adding dialysis;" "Will be starting cardio-pulmonary rehab;" "Expand cardiology - cardiac rehab center, cardiac echo;" and "Providing complementary medicine."

As discussed in the previous section, the other item, modernization of equipment, is related not only to improving services, but also building infrastructure. There is a wide variety of initiatives in this area, about a quarter of which relate directly or indirectly to radiology. Examples of purchasing and modernization of equipment include: "Enhance radiology to include ultra-sound;" "Purchasing a CT scanner;" "Major lab equipment replacement and update;" and " Mobile dental clinic."

Staffing: Staffing initiatives were cited by 11 percent of the CAH administrators (Table 8), 80 percent of whom had initiatives focusing on recruiting and retaining physicians and clinical staff (Tables 8 and 9). Approximately 60 percent of the recruiting and retaining initiatives focused on physicians and 20 percent related to recruiting and retaining non-physician clinical staff.

Financial: Only seven percent of the CAHs had initiatives in the financial domain (Table 8). Most of these initiatives related to seeking revenues and capital (Table 9). Examples include: "Want to begin a foundation to help financially;" " Looking at going after grant for networking with affiliate to provide specialists to provide care to elderly population;" and "Establishing a foundation to develop plan for new facility."

Community: Community was the least frequently cited category of initiatives (Table 8). This is reflective of the generally good relations CAH administrators report having with their communities. The majority of these initiatives focused on outreach and establishing more community presence. Only two directly related to community image/relations. Examples of outreach include "Providing community outreach on Occupational Therapy;" "Community-based wellness center;" "Planning telemedicine program for education and diabetes education for the community;" and "Establishing a farm safety program-training staff to go out to farms and educate farmers about farm safety."

The Strategic Positioning of CAHs

Critical access hospitals (CAHs) operate in the classic environment that engenders defensive strategic positioning:

- The environment is turbulent.
- The industry is in difficulty.
- The market is small.
- They have low financial strength.

However, during the first two years of our effort, there were numerous examples of CAHs that were responding with expansive, not defensive strategies. To better describe and understand this phenomenon, additional analysis was undertaken using the Year 2 telephone survey data.

As noted in the methodology section, Rowe, et. al. [1989] have identified a number of adaptive strategies which organizations can adopt: Retrenchment, Liquidation, Divestiture, Status Quo, Harvesting, Enhancement, Penetration, Market Development, Product Development, Integration, and Diversification. These 11 adaptive strategies, in turn, can be grouped into two Strategic Postures: Defensive/Conservative, Competitive/Aggressive (Figure 1).

Figure 1. Actions Related to Strategic Posturing

Defensive/Conservative	Competitive/Aggressive
• Harvesting • Status Quo • Divestiture • Liquidation • Retrenchment	• Diversification • Integration • Product Development • Market Development • Penetration • Enhancement

Examples of Defensive/Conservative strategic initiatives given by CAHs include: "Trying to maintain level of retention of doctors/recruitment of nurses;" "Trying to pay more equitably compared to other hospitals;" "Downgrading staffing;" and "Cancelled rehab contract and will do that with lab as well."

Examples of Competitive/Aggressive strategic initiatives include: "Working with other network members to expand specialty clinics;" "Want to expand mental health and add assisted living;" "We will be adding twenty thousand square feet – expanding services in that space;" and "Will begin to offer outpatient chemo and cardiac rehab."

Table 10. Classification of CAHs by Strategic Position

	%*
Defensive/Conservative	20
Competitive/Aggressive	80

** Percent equals the percent which fall into a category describing their most aggressive adaptive strategy.*

Eighty percent of the hospitals fall into the Competitive/Aggressive category when classified by their most aggressive adaptive strategy (Table 10). The magnitude of this finding was the most unanticipated outcome of the study. Incidentally, the most frequently cited competitive/aggressive adaptive strategies fell into the areas of market and/or product development.

Exploratory analyses have been conducted regarding the relationship of these results to market, administrative, and hospital-related factors. No definitive relationships have been found at this time.

Conclusion

CAH administrators are able to identify a wide range of major strengths, problems and initiatives. The Balanced Scorecard provides a useful framework for moving from viewing them individually, to viewing them in coherent groups and assessing the extent

to which hospitals adopt a strategic outlook for planning. The Balanced Scorecard framework is designed to provide a comprehensive picture, making sure that the user looks beyond financial success to the other areas ultimately affecting viability. The Balanced Scorecard groupings used in this assessment include financial, community, services, staffing and infrastructure. There are other potential rubrics for classifying long-term strategy such as "networking" or "policy involvement," but the five we have chosen represent a core set of activities that are essential to small hospital viability and which relate directly to the goals of the Flex Program. While strengths in any combination of the Balanced Scorecard area do not ensure long-term viability, major problems in these domains are indicators, at the least, of barriers that must eventually be overcome to achieve long-term viability.

Overall, the findings provide an indication that a relatively large number of CAH administrators are being fairly aggressive in their strategic positioning. They see their institutions' strengths in their governance and quality, and seem to feel that in order to be competitive, they must augment these strengths by more fully developing their infrastructure through modernizing their plants and equipment. Furthermore, they feel that cost-based reimbursement will aid in this process. While if successful, this may lead to the increased revenues and long-term viability for CAHs, it is uncertain whether these goals can be achieved without overcoming major problems in access to capital and their ability to attract and retain physicians and non-clinical staff.

References

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