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[TIRR - The Institute for Rehabilitation and Research] Long Range Planning [n.d.]

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TIRR WEAKNESSES

1. Consumer orientation, market responsiveness, general business perspectives, relationships and practices do not yet sufficiently pervade the medical staff, management, and staff, and are increasingly necessary in the changing environment. Staff are slow to adjust.
2. Present full time medical staff are fully utilized and their number must be expanded in order to gain their participation in planning strategic business units.
3. Present management team must be expanded in order to develop new strategic business units.
4. The marketing effort is under-resourced, insufficiently coordinated, and inadequate for a competitive environment. Needs organization, direction, leadership and funds.
5. The patient care areas, with the exception of the recent remodeling and expansion, do not meet the expectations of today's patients, families, and referrers (even though their needs are met). Patient meals are criticized with respect to taste, variety, presentation and temperature.
6. Many ancillary services (OT, X-Ray, Pharmacy, RT) have unattractive space that is inadequate for additional service volume from the recent bed capacity expansion.

7. Land in the Texas Medical Center proper is rapidly being used, and while we have property available, our growth options are limited to what will fit on existing parcels, or requires demolition of existing structures.
8. Most of the TMC parking (for staff and patients) is distant from our building, and is considered expensive by some of our patients and family members, who see it as a barrier, and potential employees who see it as an employment disincentive.
9. There is not yet a comprehensive, shared, long term corporate plan, developed jointly, committed to, and guiding our activities and decisions.
10. There is uncertainty regarding the future of the Department of Rehabilitation at Baylor College of Medicine. Lack of strong Baylor support.
11. Our head injury program will not grow without energetic, aggressive leadership -- the team has not been pulled together.
12. Among some referrers, we are known by many for one patient type -- severely disabled complicated patients -- "our kind". We don't get many other kinds of patients -- moderate, or mild disabilities, non-SCI. This limits our ability to grow and ties our occupancy figures (and financial performance) to one patient group. When referrals vary, we have no significant alternate source of patients.

13. Five physicians are responsible for 90% of our volume. Loss of only one of them could severely affect our service volume and financial performance (and thereby our ability to service debt). This looks risky to the rating agencies, as well as to us, and limits our access to capital by reducing our creditworthiness. The five include the following:

<u>Specialty</u>	<u>Age</u>	
Internist	56	RCG
Internist	44	LH
PM&R	43	W-D
PM&R	48	S/M
Neurologist	62	RC

14. As a single small, specialized hospital, our access to capital markets, is limited. Rating agency judgments of our creditworthiness are determined in part by this fact, and additional expense (for letters of credit, insurance, and higher interest) is required if debt is to be issued.

15. Our successful financial track record is not sufficiently long to qualify for a favorable rating by a rating agency.

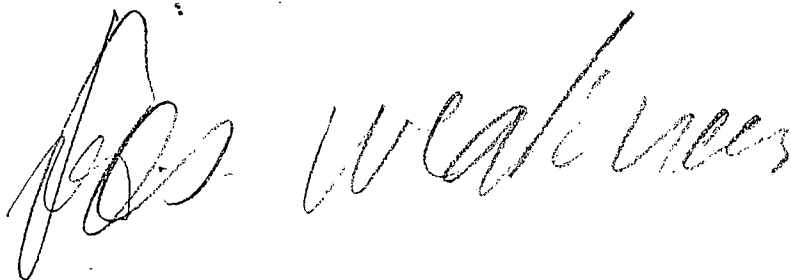
16. We need to arrange easy, daily, on-site access to an adult pulmonary specialist physician.

17. We rely, for most of our volume, on a single patient group, spinal cord injury. While this is a strength, it is also a weakness, in that it limits our flexibility. Competition in the spinal cord injury rehabilitation services market due to the PPS incentives and/or declining incidence of the problem due to successful prevention measures is likely to reduce our volume. We have not developed other markets to which we could shift.
18. We have to focus on teamwork at the management level. We have capable individuals who are not yet functioning smoothly as a team.
19. Our overhead has been too high for our revenue base. (See graph.)
20. In some areas, our service volume is inadequate to support essential backup staff.
21. We may lose patients due to delays in ascertaining the patient's financial ability to pay. Some factors we can control -- others we can only influence.
22. Our costs may be higher than others and we may lose market share if delays in handling patient equipment acquisition extend length of stay. We have not yet arrived at a satisfactory equipment handling methodology.
23. Our communication with inpatients regarding how they see the rehabilitation process, the staff, and the amenities, is inadequate in

that we do not hear about some problems until after discharge, if at all, and cannot correct them while the patient is here.

24. Our medical staff and hospital relationships with sponsors are not properly coordinated, resulting in inconsistent approach, understanding of concerns, and variable response, quality and timeliness, that strains our ties to these "customers" and costs us referrals.
25. Our treatment philosophy has been oriented primarily to an inpatient focus with outpatient service receiving low priority. The new incentives require an emphasis on reducing hospitalization and require a reversal of this approach which we have not yet achieved.
26. Uncertainty about the future, lack of agreed, long term goals, lack of clarity of the policy-making process, the desired management style and philosophy, and the clinical rehabilitation philosophy, and limited upward mobility lead to low energy, reduced morale, and staff turnover.
27. Variable, inconsistent feedback to referrers, patients and payors.
28. We have not systematized our quality promotion activities.
29. We have no corporate-level reportable statistics on outcome -- the results of rehabilitation -- that indicates the results of our efforts in an aggregate form and helps interpret to lay observers the benefits of the rehabilitation services we provide.

30. Research activities at TIRR have produced few salable products in recent years. We peaked over ten years ago with Harrington rod instrumentation, the Engen polypropylene brace, the kits for upper extremity orthoses (now marketed by Orthotic Systems, Inc.).
31. Our long history in the field may limit our creativity and willingness to break from tradition. Old methodologies may not serve us in a field where new entries are innovative. We are at risk of attempting business as usual when the tides are changing with such force that change is inevitable.
32. Appropriate functional relations among service, research, and education are only beginning to be understood and developed.
33. We have not established good mechanisms to have input into the State legislative process.
34. We lose some patients to follow-up.
35. We are not adequately active (or staffed) in disseminating materials or in training people in the region.
36. There is a lack of understanding of and appreciation for the roles of the various non-clinical departments.

 J. S. Weaver

37. Inter- and intra-departmental infighting continues. Historical independence and long-standing balanced emphasis makes integration, coordination and cooperation difficult.

38. Board members have not been as active as we have needed.

39. Having been in existence for 25 years, we continue some activities policies, attitudes and services that are not appropriate for circumstances today, and need redirection to meet current needs or pruning to free resources for new activities.

THREATS

1. Until rehabilitation becomes reimbursed on a prospective basis by Medicare, financial incentives of the Medicare Prospective Payment System (and present exemption of rehabilitation from the PPS) will decrease acute hospital occupancy, leading them to reclassify beds into rehabilitation units to escape into these cost-reimbursed segments of care.
2. There is, and will continue to be, significantly lower pressure for the acute hospitals to refer their patients to a rehab facility. Indeed, the incentives are to start rehab units and transfer patients there if reimbursement is improved thereby.
3. Entrepreneurs, as well as non-profit and for-profit chains will aggressively enter the rehab market with new facilities quickly designed, built and marketed following the (perhaps temporary) reimbursement incentives created (unintentionally?) by HCFA when they exempted rehab from the Medicare PPS. mcc
4. New entities into the rehab services market will compete for already limited professional resources. Shortages exist now, and are projected to 1990, for PM&R physicians, physical and occupational therapists. The supply of exceptionally qualified medical and other professional experts is even worse.

5. Regardless of our quality and cost, new entries into the market will reduce, perhaps temporarily, our share of certain markets, as some payors try out a new facility with no track record of results, especially if costs are lower. This may seriously reduce the volume and revenues of our present programs.
6. Need for rehabilitation services may exceed present capacity, but demand (the ability to pay for services to satisfy the need) of some financial resources appears to be close to present capacity. State agencies, (OCS, TRC) still run out of funds periodically. Their budgets are not likely to expand in proportion to proposed entries of new capacity into the market, leaving smaller slices of their reimbursement pie. These state agency funds are often used to complete the funding package for rehabilitation services for given patients).
7. Successful prevention programs (automobile crash restraints, DWI deterrence) should reduce the incidence of new spinal cord injury patients. This may not be totally offset by increases in injury due to smaller, lighter cars, failure to use restraints, and population growth. SCI cases constitute 75% of our volume.
8. Our small size, specialty nature, and short history of excellent financial performance may restrict our access to sufficient capital to do the things we need to do to compete.
9. At 95 beds, our size and volume has been too close to our break-even point for this patient and service mix, and we have been too

sensitive to changes in volume. At 115 beds we are in better shape, but must grow further to reach a conservative operating point. Limited capital access may prevent this.

10. We are too dependent on a few key physicians, the loss of any one of whom (or even their absence for vacation) significantly reduces hospital productivity and revenues. Projected shortages of key rehab experts to expand our physician cadre increase this risk.
11. Our specialization in apneic quadriplegia was affected temporarily by the unexpected loss of convenient, on-site access to our adult and pediatric pulmonary specialist physician. Other traditional professional consultation arrangements may be similarly revised unexpectedly as the effects of competition increase.
12. Loss of the single anesthesiologist could seriously curtail surgery and delay the medical rehabilitation program, or require increased transfers to acute hospitals.
13. Dallas Rehabilitation Institute is to open a 120-bed tertiary rehab facility 250 miles away in October of 1985. This facility is going to affect our catchment area, which we are going to have to expand beyond HSA-11 as we may experience some loss of market share for desirable patient populations. In 1983, we received ____ or ____% of our patients from the Dallas/Fort Worth metroplex.

14. By December 31, 1985, HCEA is to report to Congress a mechanism for including rehabilitation under the prospective payment system. It may not be one that recognizes fairly the complexity of care that our patient population requires. This could prevent efficient and effective delivery of rehabilitation services by limiting the variety of needed programs of service and the business models to provide them that are viable under the reimbursement system.
15. Not knowing what the reimbursement environment will be leaves us at risk of acquiring debt now and not being able to handle the debt service later. The new PPS system for rehabilitation or another reimbursement system (e.g., vouchers, all-payor) could adversely affect our ability to do business.
16. We are at risk of decreased volume due to bad publicity related to patient and family dissatisfaction with services, charges, and results.
17. ~~There are likely to be further cutbacks in~~ Federal grant funds for rehabilitation-related projects. *may be curtailed.*
- draft*

TIRR STRATEGIES

1. **Diversify. ~~Move into product line management.~~**

a. Expand our program in pediatric rehabilitation and consolidate our market position.

b. Modify and enlarge our head injury program capabilities and expand our market share.

c. Organize all of our general adult rehabilitation services into a program approach and expand our market share.

d. Consolidate and strengthen the market position of our spinal cord injury and amputee programs.

e. Develop additional strengths -- improve and expand programs other than SCI, for example, Surgery (hand, urology), Neurophysiology, Poly-trauma.

f. Establish a post-polio service to take advantage of our present leadership position in this region (and in the national press).

g. Build into each service program an graduate research capability for demonstrably patient benefits and cost effectiveness.

Health Fitness

2. **Recapital**

Qualitative
Trade
Joint director
re
disability
prevention

Incidence

likely amputated
prophylactic
success
regain

2. Vertically integrate.

- a. Start working directly with (large) employers on the value of rehabilitation and return to work programs for their own disabled employees to obtain the position of top rehabilitation provider and resource in the area sensitive to their concerns.
- b. Develop a group to work with new companies entering the rehabilitation field by providing consulting, management expertise through contract, and joint ventures.
- c. Organize a group of present and new internal and external specialists and support resources to develop and market educational materials and experiences for the rehab professionals and stakeholders in the related industries (e.g., insurance, health care, state government agencies, employer groups).
- d. Run the rehab components of new rehabilitation-oriented skilled nursing facilities.
- e. Shift to better organized and more comprehensive outpatient services, provided closer to home.
- f. Develop a home care service group to reduce the need for institutionalization.
- g. Establish an outreach and technical support program with formal linkages to rural rehabilitation facilities in Texas.

h. Develop (through joint ventures or syndication) (Vencare?) a skilled care facility capable of handling a percentage of healthy, ventilator dependent persons (e.g., quadriplegics, polio).

i. Create an expert assistance resource accessed by an "800" number telephone hotline for information support of physicians, rehab professionals, rehab facilities, former patients, and their families.

j. Establish a dominant position in the rehabilitation engineering and rehabilitation technology markets in the five-state region.

3. Change the conditions in the market.

a. Help HCFA to develop its recommendations to Congress to bring rehabilitation services (presently excluded) into the Medicare Prospective Payment System.

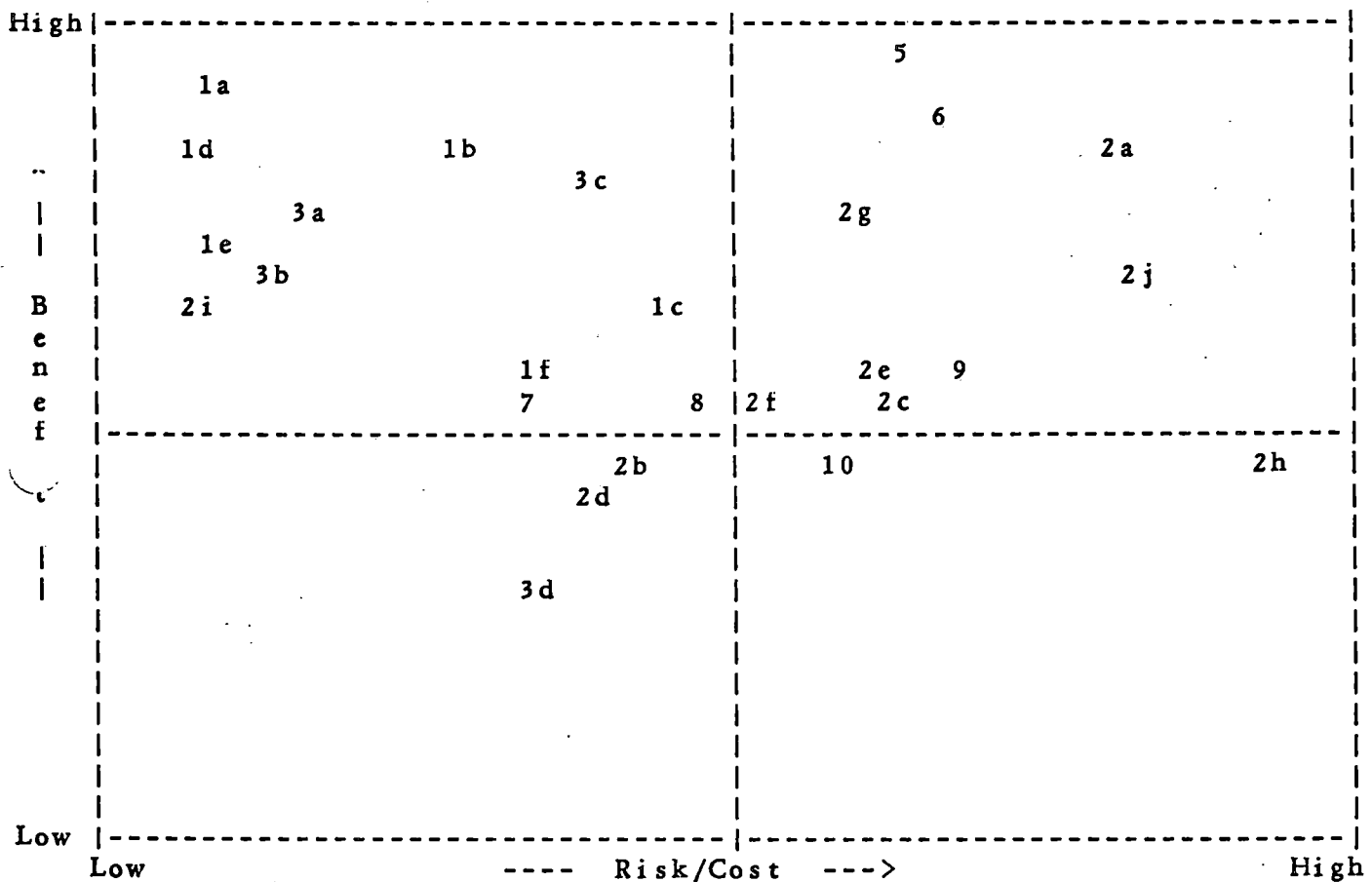
b. Work with Texas State agencies and legislators to help improve the legislation, regulations and resources that affect availability and financing of quality rehabilitation services for Texans.

c. Keep THFC hearing officers current on the facts of rehabilitation (e.g., need, demand, and resources) by presenting expert testimony at appropriate hearings.

d. Catalyze the association of similar rehabilitation facilities into an affiliation like the Voluntary Hospitals of America.

4. Position ourselves for possible future entry into the rated tax-exempt debt markets.
5. Concentrate on providing high quality rehabilitation results at lowest cost to the purchaser over the long term (rather than lowest cost in the short term) and on establishing that niche in the market and repositioning the competition.
6. *Work with people responsible and other staffs to increase sales and other revenue*
Re-organize the corporate structure to provide the business flexibility needed to seize the opportunities that present themselves. *ed paper*
7. Establish formal relationship with a Department of PM&R at UIMSH before anyone else.
8. Catalyze the creation of a self-sustaining alumni support group of Texas SCI patients like the Texas Head Injury Foundation.
9. Obtain and maintain the position (for the appropriate legal entity) as the number one and most productive rehabilitation research group in the five-state region.
10. Grow now in order to recruit and acquire commitment of limited quality staff before competition enters the staff market.

Strategy Preference



Numbers correspond to the numbered strategies, and are intended as examples. A Delphi approach will be used to obtain our preferences after discussion of each strategy and after the relevant strategic business units have been outlined.

OPPORTUNITIES

1. For the first time in history, rehabilitation is an attractive venture financially. Being experienced and knowledgeable, we can acquire or direct some of the resources into areas long of interest to us.
2. The thawing toward free competition that the PPS has brought to the health care system by DRG payment and by exemption of rehabilitation services lets us establish relationships heretofore difficult to achieve. Creative financing, organizational structures and business plans are possible and commonplace now, and will continue for several years, until things stabilize into the best feasible resourcing arrangement under the new reimbursement methodology.
3. New entries in the rehab field will need help to set up and operate rehabilitation services. Training and upgrading will be required.
4. We presently have unused physical plant capacity for inpatient and outpatient programs.
5. We have regulatory approval to grow. We already have a CCN. Others don't (yet). We can build up to 192 beds, even a complete replacement facility if we can finance it.

6. There is time to expand, consolidate and protect our market position. It will take over a year for most new entries to secure a CON, build, staff and market another facility.
7. There is unmet need for rehabilitation services in patient groups we don't presently serve. Diversification is possible.
8. New entries in the market (both investor-owned and not-for-profit) have proposed combining our expertise with their financial resources in joint ventures, management contracts, and consulting arrangements, to help create the required array of rehabilitation services in this community.
9. There is a need for education. Seminars, short courses, self-study courses, and "internships" will be necessary for emerging rehab programs at other sites.
10. There is a time window of 12-18 months before new facilities can be built or substantially converted due to CON and construction delays.
11. The health facilities planning law in Texas informs us of competitive plans and allows us to file as parties to any CON applications that affect us adversely, or for which there is clearly no demand, and to offer testimony to the Commission that affects their findings of fact.

12. There is an incentive for the major rehab facilities to cooperate and associate (with due attention to anti-trust laws).
13. High tech medicine, increased survival rates from trauma, an increasing number of persons over 65 with major disability and with chronic disease is increasing the need for restorative and rehabilitation services.
14. There is a growing need for transitional care (home care, congregate living), as well as long-term custodial care.
15. Some programs of our competitors are vulnerable to an alternative entry with a different focus and approach.
16. We are aware of no pediatric rehabilitation program in the area, other than our small one.
17. Baylor's PM&R Department has the potential to operate several bed services here.
18. We can collaborate with the University of Texas, Rice University, University of Houston, Texas A & M University, and others in programs of mutual interest and benefit.
19. New funds are available from the private sector.
20. We can fill a gap that now exists and increase

deinstitutionalization and independent living.

21. Former patients may be organized into alumni supporters.
22. We have new board members and new board leadership. They may become more involved in the mission.
23. We are generating internal funds that can be used to finance new ventures.
24. Local businesses are now following the national trend and are increasingly aware of the return that is possible on an investment in rehabilitating their workers compensation claimants and returning them to work. They will need guidance and resources to do so.

TIRR STRENGTHS

1. Strong, visible, respected, and recognized program in spinal cord injury rehabilitation. Particularly recognized for excellent management of the apneic quadriplegic patient and patients with multiple trauma.
2. Small, but strong, visible program in amputee services.
3. Experienced, respected and recognized medical staff and consultants.
4.  Strong, experienced department directors and professional staff involved in service, research and education.
5. Dedicated and loyal staff.
6. Availability of a full range of needed services, surgical, medical, diagnostic, therapeutic, rehabilitative, managerial and technological resources, most on site, with others available in the TMC.
7. Established, long-standing linkage to the primary trauma centers in the HSA-11 13-county area.

8. Location in Texas Medical Center with strong linkages to and cooperation with other TMC institutions (image, service supports). The image and reputation of TMC and its constituent institutions is the highest. Outside health facilities cluster around it.
9. Located in large potential referral base (large, growing population center), community need for services.
10. Affiliation with a medical school (Baylor College of Medicine) that has one of the highest reputations in the country, and offers high quality support in every clinical area.
11. Historically, a national and international reputation for quality patient care, excellent results and beneficial innovations. Quality of care in the programs maintained by direct supervision of qualified senior physicians and experienced professional specialists.
12. Full accreditation by JCAH and CARE.
13. We know more about how to do quality rehabilitation than most groups in the region.
14. Long-established and continually improving relationships with payor groups and referrers in the region.
15. Twenty-five years of successful service and marketing to more than 30,000 patients and families from all states and 30 foreign countries.

16. "Graduates" of our residency programs, and our various educational and staff development programs become referrers.
17. A reputation for conducting excellent research and demonstration programs, with a history of certain recognized innovations in rehabilitation medicine, surgery, technology, and rehabilitation practice.
18. Innovation and application of technology (including high technology) is routine at TIRR. We are comfortable with it, we know how to innovate as well as apply it, and we have been doing it for years.
19. A large, intensive, leading edge research program in restorative neurology and clinical neurophysiology, privately funded, and international in scope.
20. Our Independent Living Research Utilization program is nationally recognized and effective, and links us into a wide network of resources.
21. Many of our staff occupy influential leadership positions in national, state, and local industry (AAPM&R, ASIA, ACRM, AAOS, NARF, ICM/NAS, CARE, AHA, GHSC, AAP, etc), government advisory groups and consortia. We have been, and continue to be, involved in establishing various standards for the rehabilitation field.
22. Teaching programs in conjunction with universities and schools for health professions, locally, state, and nationwide.

23. Strong and involved Board Executive Committee and Board of Trustees, with effective linkages and relationships with the community representatives and access to resources.
24. We have not yet reached our potential in any area, and this keeps staff here and excited.
25. Alert, capable management team, experienced in and familiar with the rehabilitation field, and capable of moving the organization to its goals.
26. Excellent payor mix -- largely private, third party insurance (casualty and worker's compensation) with small (12% Medicare) cost payor base.
27. Recently completed new bed space, ancillary space, outpatient department expansion.
28. We have a certificate of need for additional capacity.
29. Historically high occupancy rates.
30. Most financial ratios better than industry standards.
31. Staff are ready for and will get excited about a clear direction for TIRR.

32. TIRR has an institutional reputation that may transcend the programs, and that may attract referrals to programs we offer.
33. We are involved in various forums that are developing recommending to HCFA an appropriate reimbursement mechanism for rehabilitation.
34. We own almost a whole city block of land outside of the Texas Medical Center at our annex site. Almost half the property is undeveloped, and has no covenants (like TMC property) that prohibit a build/lease back financing with investor groups.
35. Staff involvement with consumer groups.
36. Dedication and commitment of staff to a behavior and philosophy.

Adapted with permission by Lex Frieden from an original paper by Don Galvin entitled "Principles of Strategic Planning Process".

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- I. Overview
- II. The Concept of Strategic Planning
- III. The "Bits and Pieces" of Strategic Planning
 - A. The Mission Audit
 - B. Assessment of the Current Strategy
 - C. Assessment of the Organizations' Internal Environment with Emphasis upon Strengths and Weaknesses
 - D. External Environment Trend Analysis with Emphasis on Opportunities and Threats
 - E. Setting the Strategic Direction
 - F. Financial Projections
- IV. Conclusion

I. Overview:

The terms "strategic planning" and "long range planning" are sometimes used interchangeably. Since strategic planning takes a long range view (usually three to five years into the future) the interchangeability is understandable. However, since the term "long range planning" suggests only the time frame for planning, the author prefers the term strategic planning. It is felt that the process of raising fundamental questions, identifying alternatives, establishing priorities and looking at the BIG PICTURE precedes and sets the foundation for more specific program, financial and human resource plans. Strategic planning raises the fundamental questions - "What is to be done and why?" - before moving on to the more pragmatic question - "How to do it?" Simply put, an organization should know in what directions it wishes to move before determining how to get there. Strategic planning thus forces us to differentiate and agree upon ends and means.

II. The Concept of Strategic Planning

Merritt L. Kastens (1980) best summarizes the several elements of strategic thinking. Kastens asserts that following strategic planning, managers should be able to affirmatively state:

- o Here's how we perceive the situation
- o Here's what we believe will happen
- o Here's how we may be affected and,
- o Here's what we intend to do about it.

Tulloch (1983) has defined strategic planning as "the decision making process that the executive team of an organization uses to decide the nature of its business and establish goals and priorities for the future." Effective strategy helps the organization (1) establish priorities in allocating money and time resources; (2) determine those policies which implement the strategy; and (3) decide the products or markets in which the organization chooses to compete. Strategic planning may be described as a process that directs an organization's attention to the future, thereby enabling it to adopt more readily to change, determine the direction in which it chooses to move, and help the organization "invent" its future. Strategic planning may thus be preferred to as a learning process and a form of organizational insurance.

III. THE "BITS AND PIECES" OF STRATEGIC PLANNING

George Stuehler in 1980 gave us perhaps the best overview statement of the strategic planning process when he wrote; "An institution's survival depends on an understanding of (1) its strengths, weaknesses, and problems; on an (2) understanding of its environment - the threats, opportunities, risks, and needs; and (3) an organized effort to develop a mission and role, goals and strategies, and (4) to select means for accomplishment." (George Stuehler, 1980)

The paramount strategic planning tasks involve:

- o A mission audit
- o Assessment of current strategy
- o Assessment of the organization's internal environment with emphasis on strengths and weaknesses
- o Assessment of external environment trends with emphasis on opportunities and threats
- o Selection of strategies and objectives
- o Financial projections

A. THE MISSION AUDIT: WHO ARE WE?

Sooner or later, every organization must face up to the task of defining its basic purposes and mission. All health care and rehabilitation organizations have an explicitly stated or implicit mission, generally consisting of a statement that identifies in broad terms the purposes for which the organization exists. The mission statement specifies the unique aim of the organization and serves to differentiate the organization from all others. The mission statement may identify (a) consumers and/or markets served, (b) benefits and services provided by the organization, (c) special technology and/or expertise utilized to meet consumer needs, (d) the organizations' philosophical foundation, its value orientation and legal status.

The Mission Audit is the first of the major tasks of strategic planning. This objective probe is the key to the entire process because it often uncovers challenges and opportunities for change and sets the tone for all that follows. It is evident that the strategic planning process cannot get under way until the all important matter of the organization's mission is settled and accepted by the organization's executives and governance board.

B. IDENTIFICATION OF CURRENT STRATEGY: WHERE ARE WE NOW?

Whether the organization has consciously formulated a strategy or not, it cannot escape its' past, its' assumptions, its' response proclivities. The following questions from Webber and Peters (1983) may prove useful in identifying the organization's current strategy:

1. Which phrase most accurately describes the organization's values with respect to the outside world?
 - o Don't get involved
 - o Roll with the punches
 - o Dream ahead
 - o Plan ahead
2. How does the organization react to change?
 - o Does nothing
 - o Rejects or resists change
 - o Adapts to change
 - o Seeks change
 - o Anticipates change
 - o Creates a desired future
3. What is the organization's growth strategy?
 - o Exits gracefully
 - o Maintains its' present position
 - o Increases the market share of present services in its traditional service area
 - o Grows selectively, specializes in certain services, or caters to defined markets
 - o Converts the organization or an underutilized unit to another use
 - o Closes the facility
4. Strategic thrust: What are the two or three most important driving forces behind the organization's present direction?
 - o Tradition and past successes
 - o Outside sanctions and incentives, including reimbursement
 - o Staff demands and expectations
 - o Results (for example, finances or quality of care)
 - o Services offered
 - o Market forces, including keeping up with the competition

5. What is the organization's role in multi-institutional arrangements:
 - o Goes it alone
 - o Builds on existing affiliations
 - o Is part of a multi-institutional system
 - o Links organizations through new networks, cooperative agreements, contracts, consortia
6. What is the organization's approach to managing external affairs?
 - o Responds independently (does its "own thing")
 - o Responds cooperatively with those who have an interest in the future of the organization
 - o Attempts to influence regulators and outside control groups
 - o Forms and joins coalitions
 - o Alters the outside world through political action, professional associations, and other interest groups
7. In what research activities is the organization involved?
 - o No research activities
 - o Limited clinical research
 - o Broad array of basic and clinical research programs
 - o Cooperates with a university or research institute
8. Which phrase best describes the organization's position with respect to keeping abreast of advances in rehabilitation?
 - o Does not attempt to keep pace with new advances
 - o Lags behind other local organizations
 - o Follows the leader
 - o Responds quickly to new technology and replicates
 - o Usually the leading innovator in its' market area

The answers to these reveals the set of assumptions, traditions, and habits which informally, (but purposefully) influence the organization's strategic responses and decisions. Unfortunately, this response pattern may be wholly inappropriate in the fact of the new future presented by The Rehab. Act; The Tech Act; and other legislative and policy initiatives.

C. ASSESSMENT OF THE ORGANIZATION'S INTERNAL ENVIRONMENT
WITH EMPHASIS UPON STRENGTHS AND WEAKNESSES

Several strategic planning authorities (Tulloh, 1983; Peters, 1985; Pegels and Rogers, 1988) recommend the use of "S.W.O.T. Analysis" by which internal Strengths and Threats and Weaknesses and external (or environmental) Opportunities and Threats provide the analytical framework.

The organization is advised to 'know itself' which is simply by way of saying that the organization must identify its strengths and uncover its weaknesses or limitations. In discussing the strategic planning process for hospitals, Peters (1985) recommends an analysis of the strengths and weaknesses among the following internal factors:

- o Management including the Board of governance
- o Functional programs and services
- o Staff resources
- o Financial resources and results
- o Physical facilities
- o Basic values and corporate culture
- o Interrelationships among the above comprehensive summary of the internal organization and operations.

The findings of this analysis describe the anatomy of the organization. To obtain a more comprehensive perspective and appreciation of what is taking place within the organization, management must understand how the various elements are interrelated, how they affect each other, how they contribute to the public's perception of the institution, etc. In short, the internal findings should be organized into a meaningful profile that summarizes the overall health of the organization and its capacity to cope successfully with outside change.

D. EXTERNAL ENVIRONMENT TREND ANALYSIS WITH EMPHASIS ON
OPPORTUNITIES AND THREATS

It is essential for managers to learn to scan, to read, to analyze the environment. They must have the capacity to detect early signs of change, threat, challenge and opportunity from the array of data and evidence available. As Peters and Waterman (1982) state, "Innovative companies are especially adroit at continually responding to change of any kind in their environments." It is recommended that the external environment trend analysis should be conducted at the macro (or national) level and at the micro (or local) level. For example, strategic planning might reflect the following:

1. National Trends:

... in terms of opportunities:

- o Demographic and incidence/prevalence data which might reflect the need for services.
- o Legislative initiatives, i.e. Rehab Act, "Tech Act," etc.
- o Public confidence in power, impact of rehabilitation

... in terms of threats:

- o Economic and reimbursement issues
- o Public perception that rehabilitation is overly expensive
- o Fragmentation of rehabilitation "industry"
- o Career preparation and development concerns among key personnel
- o Limited national experience and guidance in implementing new services

2. Local/Regional Trends

... in terms of opportunities:

- o State VR agency commitment to agency
- o Market demand for services in terms of local need for such services
- o Little or no competition - few rehabilitation services, available in local area

... in terms of threats:

- o History of limited cooperation between relevant agencies and organizations
- o Strong "turf" conflicts with occupational therapists and prosthetic/orthotic specialists
- o Local insurance companies' refuse to reimburse for services

E. SETTING THE STRATEGIC DIRECTION: WHERE DO WE WANT TO GO?

Now that assistive technology managers have performed the ecological assessment noted above, they can move on to consider those strategies which set the stage for operational programs. Webber and Peters (1983) identify the following major strategic options:

- o Growth strategies (an increase in size or number)
- o Development strategies (an increase in capacity or potential)
- o Collaborative strategies (mergers, joint ventures, cooperative agreements, contract management)
- o Product portfolio or service mix strategies (niches, specializations)
- o Diversification strategies with the caveat that the organization should consider only those new services that it already knows how to manage
- o Defensive strategies which include implementation of new services, in part, to discourage competitors from entering the area
- o Abandonment strategies which include down-sizing or terminating services and programs. (It is a sign of wisdom to know when to stop, as well as when to start, an activity).

The selection of strategies and strategic direction requires attention to the following questions and assumptions:

1. What consumers will the organization serve, with what services, using what technologies?
2. How will the organization secure the support of, or deal with the opposition from, important internal and external groups, i.e. agency staff, government officials, advocacy groups; other rehabilitation organizations?
3. What tactics will the organization use in dealing with competitors?
4. How will the necessary personnel and skills be obtained?
5. What changes in organizational structure will be necessary?
6. What is the time frame for making these changes?
7. How will the organization finance the changes?
8. What is to be accomplished during the first six months? In the first year? Within five years?

It is obvious from the above that the strategic and planning process requires rather substantial amounts of information. The organization planning to initiate or enhance services needs to assemble:

1. Information about the area to be served
 - o social-economic factors
 - o population demographics
 - o education level
 - o housing
 - o transportation
2. Information about the clients to be served
 - o age groups
 - o source of referrals
 - o diagnostic categories
 - o impairments
 - o rehabilitation needs
3. Information about the services to be provided
 - o service classification
 - o service statistics
 - o level of technology
4. Information about the staff of the organization
 - o staff experience and expertise
 - o staff organization
 - o staff composition, specializations
 - o staff recruitment needs
 - o staff development and continuing education
5. Information about financial operations and results
 - o reimbursement for services
 - o budget statements
 - o product line costs
6. Information about other rehabilitation organizations in the area
 - o location
 - o client populations
 - o unique or specialized services
 - o performance and existing market share
 - o position/image in the community

F. FINANCIAL PROJECTIONS

Eventually strategies, programs, and actions must be translated into "bottom line" realities. In this step the planning team identifies the total capital required to carry out the strategies they have developed. This information provides the necessary information for the Chief Financial Officer (who should be a member of the strategic planning team) to prepare financial projections. These projections summarize the total commitment of financial resources required by the strategic plan and the financial benefits and results expected to flow from the actions to be taken. This section of the strategic plan also provides the core information required in the business plan for all new program initiatives.

IV. CONCLUSION

Webber and Peters (1983) emphasize that strategic thinking imposes rationality on the management process as it helps managers anticipate the future and make contingency plans based upon a critical analysis of present and future trends, emerging issues, and new opportunities and threats. By its very nature strategic planning is an umbrella activity that sets the tone and direction for various subsidiary planning efforts, i.e. program plans, departmental plans or administrative support plans, e.g. financial, facility, human resources, marketing.

The nature of strategic planning is such that the analysis of issues and decision making is an iterative or cyclical process which should flow as simply and as naturally as possible. Strategy planning may be described as a continuous, evolving, consensus building process with no precise beginning or end.

Strategic planning also forces top management to clearly distinguish between means and end, to carefully consider the alternative means available to accomplish its goals and objectives and to appreciate the consequences of its decisions. Accordingly, Peter Drucker (1959) has observed that strategic planning "deals with the futurity of today's decision".

It should be recognized that strategic planning is not a science. Rather, the ultimate test is to find a good, doable strategy - simply put - one that works!

James Brian Quinn in Strategies for Change (1980) argues for what he calls "Logical Incrementalism". Instead of mapping out all the steps in some grand scheme, he advises that top management should decide on the general direction of change and take one small step, followed by another, and another, etc. The advantage of such strategy is that such small steps do not create undue threat, the organization has more time to adjust and there is time to plan each step. Thus, managers would be advised to attempt to move in several directions at the same time, but rather to focus on the most important trends and key result areas (Deegan and O'Donovan, 1982).

Mintzberg (1987) states that the success of the strategic planning effort does not depend so much on conceptual sophistication and cool rationality as upon involvement, intimacy, and harmony with the subject at hand, developed through long experience and commitment. In his words, "The notion that strategy happens way up there, far removed from the details of running an organization on a daily basis, is one of the great fallacies of conventional strategic management." Mintzberg speaks about "discovering" strategies at the grass roots level.

Unfortunately many of the strategic choices made by managers are merely extensions of past experience rather than products of future-oriented thinking. That is, too often today's strategic decisions are based upon yesterday's successes. Further, the difficulty of determining and choosing among strategic alternatives leads many managers to do what the rest of the industry is doing rather than making independent and creative choices. Managers also need to recognize that they will always be confronted by some degree of uncertainty and risk. In the final analysis it is the execution of the basics of management, i.e., judgment, decision, commitment and implementation which are decisive.

The ultimate test of strategic planning is: if it was worth all the effort. In terms of evaluating benefits derived from strategic planning the organization's governing body and responsible managers should ask themselves:

1. Does the strategic plan provide a clear sense of direction for future efforts?

2. Is the plan sensitive to outside threats and opportunities, and their potential impact on the organization?

3. Does the strategy reflect (a) the values and aspirations of the board and management (b) shared corporate values (c) desired organizational commitment to the community?

4. Will the strategy help the board and management decide on future programs, services, clientele?

EXECUTIVE SUMMARY

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- I OVERVIEW
- II THE CONCEPT OF STRATEGIC PLANNING
- III THE "BITS AND PIECES" OF STRATEGIC PLANNING
 - A. THE MISSION AUDIT
 - B. ASSESSMENT OF THE CURRENT STRATEGY
 - C. ASSESSMENT OF THE ORGANIZATIONS' INTERNAL ENVIRONMENT WITH EMPHASIS UPON STRENGTHS AND WEAKNESSES
 - D. EXTERNAL ENVIRONMENT TREND ANALYSIS WITH EMPHASIS ON OPPORTUNITIES AND THREATS
 - E. SETTING THE STRATEGIC DIRECTION
 - F. FINANCIAL PROJECTIONS

~~IV OPERATIONAL PLANNING AND IMPLEMENTATION~~

~~V ORGANIZING FOR STRATEGIC PLANNING~~

~~VI THE ULTIMATE TEST OF STRATEGIC PLANNING~~

IV

Conclusion

I OVERVIEW:

The purpose of this chapter is to familiarize readers with the strategic planning process and its application to operational planning and program implementation with special reference to ~~assistive technology~~. The organization of the strategic planning effort and an assessment of the impact or benefits of strategic planning are ~~also addressed~~.

The terms "strategic planning" and "long range planning" are sometimes used interchangeably. Since strategic planning takes a long range view (usually three to five years into the future) the interchangeability is understandable. However, since the term "long range planning" suggests only the time frame for planning, the author prefers the term strategic planning. It is felt that the process of raising fundamental questions, identifying alternatives, establishing priorities and looking at the BIG PICTURE preceeds and sets the foundation for more specific program, financial and human resource plans. Strategic planning raises the fundamental questions - "What is to be done and why?" - before moving on to the more pragmatic question - "How to do it?" Simply put, an organization should know in what directions it wishes to move (~~with regard to assistive technology, for example~~) before determining how to get there. Strategic planning thus forces us to differentiate and agree upon ends and means.

II The Concept of Strategic Planning

Merritt L. Kastens (1980) best summarizes the several elements of strategic thinking. Kastens asserts that following strategic planning, managers should be able to affirmatively state:

- o Here's how we perceive the situation
- o Here's what we believe will happen
- o Here's how we may be affected and,
- o Here's what we intend to do about it.

Tulloh (1983) has defined strategic planning as "the decision making process that the executive team of an organization uses to decide the nature of its business and establish goals and priorities for the future." Effective strategy helps the organization (1) establish priorities in allocating money and time resources; (2) determine those policies which implement the strategy; and (3) decide the products or markets in which the organization chooses to compete. Strategic planning may be described as a process that directs an organization's attention to the future, thereby enabling it to adopt more readily to change, determine the direction in which it chooses to move, and help the organization "invent" its future. Strategic planning may thus be preferred to as a learning process and a form of organizational insurance.

Leaders in Assistive Technology require a comprehensive, rational approach which will improve their

Start here

view of the future and their capacity to capitalize upon opportunities while avoiding obstacles and resolving problems. Strategic planning, followed by systemic implementation, provides this capacity.

III THE "BITS AND PIECES" OF STRATEGIC PLANNING*

George Stuehler in 1980 gave us perhaps the best overview statement of the strategic planning process when he wrote; "An institution's survival depends on a understanding of (1) its strengths, weaknesses, and problems; on an (2) understanding of its environment - the threats, opportunities, risks, and needs; and (3) an organized effort to develop a mission and role, goals and strategies, and (4) to select means for accomplishment." (George Stuehler, 1980)

The paramount strategic planning tasks involve:

- o A Mission Audit
- o Assessment of Current Strategy
- o Assessment of the Organization's Internal Environment with Emphasis on Strengths and Weaknesses
- o Assessment of External Environment Trends with Emphasis on Opportunities and Threats

* This section owes much to the following sources; "An Action - Oriented Approach to Strategic Planning Consultation: by Charles Tulloh (1983) and a Strategic Planning Process For Hospitals by Joseph P. Peters (1985). Both sources emphasize a systematic process involving organizing for planning and deliberate consideration of a series of specific topics involving organizing for planning and deliberate consideration of a series of specific topics or tasks.

- o Selection of Strategies and Objectives
- o Financial Projections

A. THE MISSION AUDIT: WHO ARE WE?

Sooner or later, every organization must face up to the task of defining its basic purposes and mission. All health care and rehabilitation organizations have an explicitly stated or implicit mission, generally consisting of a statement that identifies in broad terms the purposes for which the organization exists. The mission statement specifies the unique aim of the organization and serves to differentiate the organization from all others. The mission statement ~~of the assistive technology organization~~ may identify (a) consumers and/or markets served, (b) benefits and services provided by the organization, (c) special technology and/or expertise utilized to meet consumer needs (d) the organizations' philosophical foundation, its value orientation and legal status.

The Mission Audit is the first of the major tasks of strategic planning. This objective probe is the key to the entire process because it often uncovers challenges and opportunities for change and sets the tone for all that follows. It is evident that the strategic planning process cannot get under way until the all important matter of the organization's mission is settled and accepted by the organization's executives and governance board.

The organization considering an application for funds under provisions of the Technology Related Assistance for Individuals with Disabilities Act of 1988 must first determine if such technology related services appropriately fits within its mission, goals and objectives. A careful reading of the "Tech Act", an assessment of the organization's present status, and gathering information about the agency itself and its' environment are logical next steps.

B. IDENTIFICATION OF CURRENT STRATEGY: WHERE ARE WE NOW?

Whether the ~~assistive technology~~ organization has consciously formulated a strategy or not, it cannot escape its' past, its' assumptions, its's response proclivities. The following questions from Webber and Peters (1983) may prove useful in identifying the organization's current strategy:

1. Which phrase most accurately describes the organizations values with respect to the outside world?
 - o Don't get involved
 - o Roll with the punches
 - o Dream Ahead
 - o Plan Ahead

2. How does the organization react to change?
 - o Does nothing
 - o Rejects or resists change
 - o Adapts to change
 - o Seeks change
 - o Anticipates change
 - o Creates a desired future
3. What is the organization's growth strategy?
 - o Exits gracefully
 - o Maintains its' present position
 - o Increases the market share of present services in its traditional service area
 - o Grows selectively, specializes in certain services, or caters to defined markets
 - o Converts the organization or an underutilized unit to another use
 - o Closes the facility
4. Strategic thrust: What are the two or three most important driving forces behind the organization's present direction?
 - o Tradition and past successes
 - o Outside sanctions and incentives, including reimbursement
 - o Staff demands and expectations
 - o Results (for example, finances or quality of care)
 - o Services offered
 - o Market forces, including keeping up with the competition

5. What is the organization's role in multi-institutional arrangements:
 - o Goes it alone
 - o Builds on existing affiliations
 - o Is part of a multi-institutional system
 - o Links organizations through new networks, cooperative agreements, contracts, consortia
6. What is the organization's approach to managing external affairs?
 - o Responds independently (does its "own thing")
 - o Responds cooperatively with those who have an interest in the future of the organization.
 - o Attempts to influence regulators and outside control groups
 - o Forms and joins coalitions
 - o Alters the outside world through political action, professional associations, and other interest groups
7. In what research activities is the organization involved?
 - o No research activities
 - o Limited clinical research
 - o Broad array of basic and clinical research programs
 - o Cooperates with a university or research institute

8. Which phrase best describes the organization's position with respect to keeping abreast of advances in

~~Assistive Technology?~~ *that*

- o Does not attempt to keep pace with new advances
- o Lags behind other local organizations
- o Follows the leader
- o Responds quickly to new technology and replicates
- o Usually the leading innovator in its' market area

The answers to these reveals the set of assumptions, traditions, and habits which informally, (but purposefully) influence the organization's strategic responses and decisions. Unfortunately, this response pattern may be wholly inappropriate in the face of the new future presented by The Rehab. Act; The Tech Act; and other legislative and policy initiatives.

C. ASSESSMENT OF THE ORGANIZATION'S INTERNAL ENVIRONMENT
WITH EMPHASIS UPON STRENGTHS AND WEAKNESSES

Several strategic planning authorities (Tulloh, 1983; Peters, 1985; Pegels and Rogers, 1988) recommend the use of "S.W.O.T. Analysis" by which internal Strengths and Threats and Weaknesses and external (or environmental) Opportunities and Threats provide the analytical framework.

The ~~assistive technology~~ organization is advised to "know itself" which is simply by way of saying that the organization must identify its strengths and uncover its weaknesses or limitations. In discussing the strategic planning process for hospitals, Peters (1985) recommends an analysis of the strengths and weaknesses among the following internal factors:

- o Management including the Board of governance
- o Functional programs and services
- o Staff Resources
- o Financial resources and results
- o Physical facilities
- o Basic values and corporate culture
- o Interrelationships among the above comprehensive summary of the internal organization and operations.

For example, an ~~assistive technology~~ organization might note the following internal strengths and weaknesses:

Strengths

- o Implementation of successful wheelchair, seating, and augmentative communication programs.
- o Highly expert, visible senior staff
- o Active participation in professional organizations ~~i.e., RESNA.~~
- o Commitment to professional values and standards.
- o ~~Dramatic increase in referrals for assistive technology and services.~~

Weaknesses

- o Significant shortages among important staff, ~~i.e.~~
~~technicians, engineers, therapists,~~
- o Limited opportunity for service reimbursement or payment.
- o Limited experience in serving infants and children
- o Lack of a marketing perspective
- o No prior experience in writing successful research or program proposals.

of this analysis
These findings describe the anatomy of the organization.

To obtain a more comprehensive perspective and appreciation of what is taking place within the organization, management must understand how the various elements are interrelated, how they affect each other, how they contribute to the public's perception of the institution, etc. In short, the internal findings should be organized into a meaningful profile that summarizes the overall health of the organization and its capacity to cope successfully with outside change.

D. EXTERNAL ENVIRONMENT TREND ANALYSIS WITH EMPHASIS ON OPPORTUNITIES AND THREATS

It is essential for ~~assistive technology~~ managers to learn to scan, to read, to analyze the environment. They must have the capacity to detect early signs of change, threat, challenge and opportunity from the array of data and evidence available. As Peters and Waterman (1982) state, "Innovative companies are especially adroit at continually responding to change of any kind in their environments." It is recommended that the external environment trend analysis should be

conducted at the macro (or national) level and at the micro (or local) level. For example, strategic planning ~~for assistive technology~~ might reflect the following:

1. NATIONAL TRENDS:

... in terms of opportunities:

- o Demographic and incidence/prevalence data which might reflect the need for assistive technology services.
- o Legislative initiatives i.e. Rehab Act, "Tech Act," etc.
- o Public confidence in power, impact of ~~technology~~ *rehab*

... in terms of threats:

- o Economic and reimbursement issues
- o Public perception that assistive technology is overly expensive *rehab*
- o Fragmentation of assistive technology "industry" *rehab*
- o Career preparation and development concerns among assistive technology personnel. *key*
- o Limited national experience and guidance in implementing assistive technology services. *rehab*

2. LOCAL/REGIONAL TRENDS

... in terms of opportunities:

- o State VR agency commitment to assistive technology. *Agency*
- o Market demand for assistive technology in terms of local ~~school district's pronounced~~ need for such services. *services*
- o Little or no competition - few existing assistive technology services, available in local area. *rehab*

... in terms of threats:

- o History of limited cooperation between relevant agencies and organizations.
- o Strong "turf" conflicts with occupational therapists and prosthetic/orthotic specialists.
- o Local insurance companies' refuse to reimburse for assistive technology.

E. **SETTING THE STRATEGIC DIRECTION: WHERE DO WE WANT TO GO?**

Now that assistive technology managers have performed the ecological assessment noted above, they can move on to consider those strategies which set the stage for operational programs. Webber and Peters (1983) identify the following major strategic options:

- o Growth strategies (an increase in size or number)
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In the first year? Within five years?

It is obvious from the above that the strategic and planning process requires rather substantial amounts of information. The organization planning to initiate or enhance ~~assistive technology~~ services needs to assemble:

1. Information about the area to be served.
 - o Social-economic factors
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F. FINANCIAL PROJECTIONS

Eventually strategies, programs and actions must be translated into "bottom line" realities. In this step the planning team identifies the total capital required to carry out the strategies they have developed. This information provides the necessary information for the Chief Financial Officer (who should be a member of the strategic planning team) to prepare financial projections. These projections summarize the total commitment of financial resources required by the strategic plan and the financial benefits and results expected to flow from the actions to be taken. This section of the strategic plan also provides the core information required in the business plan for all new program initiatives.

(Easter Seal, 1985)

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*IV. Conclusion
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5. Will the strategy be helpful in terms of setting priorities, allocating resources, space, time?
6. Is the strategy easy to communicate?
7. Is the strategy responsive to competition?
8. Is the strategy reasonable and workable? Can it be translated into action oriented operational plans?

CONCLUSION:

Webber and Peters (1983) emphasize that strategic thinking imposes rationality on the management process as it helps managers anticipate the future and make contingency plans based upon a critical analysis of present and future trends, emerging issues, and new opportunities and threats. By its very nature strategic planning is an umbrella activity that sets the tone and direction for various subsidiary planning efforts, i.e. program plans, departmental plans or administrative support plans e.g. financial, facility, human resources, marketing.

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Quoted from 23, 24

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Sum of letters
VI THE ULTIMATE TEST OF STRATEGIC PLANNING WAS IT WORTH ALL THE EFFORT? *U.S.*

Sum of letters
In terms of evaluating benefits derived from strategic planning the organization's governing body and responsible managers should ask themselves:

1. Does the strategic plan provide a clear sense of direction for future efforts?
2. Is the plan sensitive to outside threats and opportunities, and their potential impact on the organization?
3. Does the strategy reflect (a) the values and aspirations of the board and management (b) shared corporate values (c) desired organizational commitment to the community?
4. Will the strategy help the board and management decide on future programs, services, clientele?

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TIRR STRATEGIES

1. **Diversify. ~~Move into product line management.~~**

a. Expand our program in pediatric rehabilitation and consolidate our market position.

b. Modify and enlarge our head injury program capabilities and expand our market share.

c. Organize all of our general adult rehabilitation services into a program approach and expand our market share.

d. Consolidate and strengthen the market position of our spinal cord injury and amputee programs.

e. Develop additional strengths -- improve and expand programs other than SCI, for example, Surgery (hand, urology), Neurophysiology, Poly-trauma.

f. Establish a post-polio service to take advantage of our present leadership position in this region (and in the national press).

g. Build into each service program an evaluation research capability for demonstrable patient benefits and cost effectiveness.

Health fitness

2 Recapture

geriatric
stroke
joint disease
rehabilitation

incidence
early competition
success required

2. Vertically integrate.

- a. Start working directly with (large) employers on the value of rehabilitation and return to work programs for their own disabled employees to obtain the position of top rehabilitation provider and resource in the area sensitive to their concerns.
- b. Develop a group to work with new companies entering the rehabilitation field by providing consulting, management expertise through contract, and joint ventures.
- c. Organize a group of present and new internal and external specialists and support resources to develop and market educational materials and experiences for the rehab professionals and stakeholders in the related industries (e.g., insurance, health care, state government agencies, employer groups).
- d. Run the rehab components of new rehabilitation-oriented skilled nursing facilities.
- e. Shift to better organized and more comprehensive outpatient services, provided closer to home.
- f. Develop a home care service group to reduce the need for institutionalization.
- g. Establish an outreach and technical support program with formal linkages to rural rehabilitation facilities in Texas.

- h. Develop (through joint ventures or syndication) (Vencare?) a skilled care facility capable of handling a percentage of healthy, ventilator dependent persons (e.g., quadriplegics, polio).
- i. Create an expert assistance resource accessed by an "800" number telephone hotline for information support of physicians, rehab professionals, rehab facilities, former patients, and their families.
- j. Establish a dominant position in the rehabilitation engineering and rehabilitation technology markets in the five-state region.

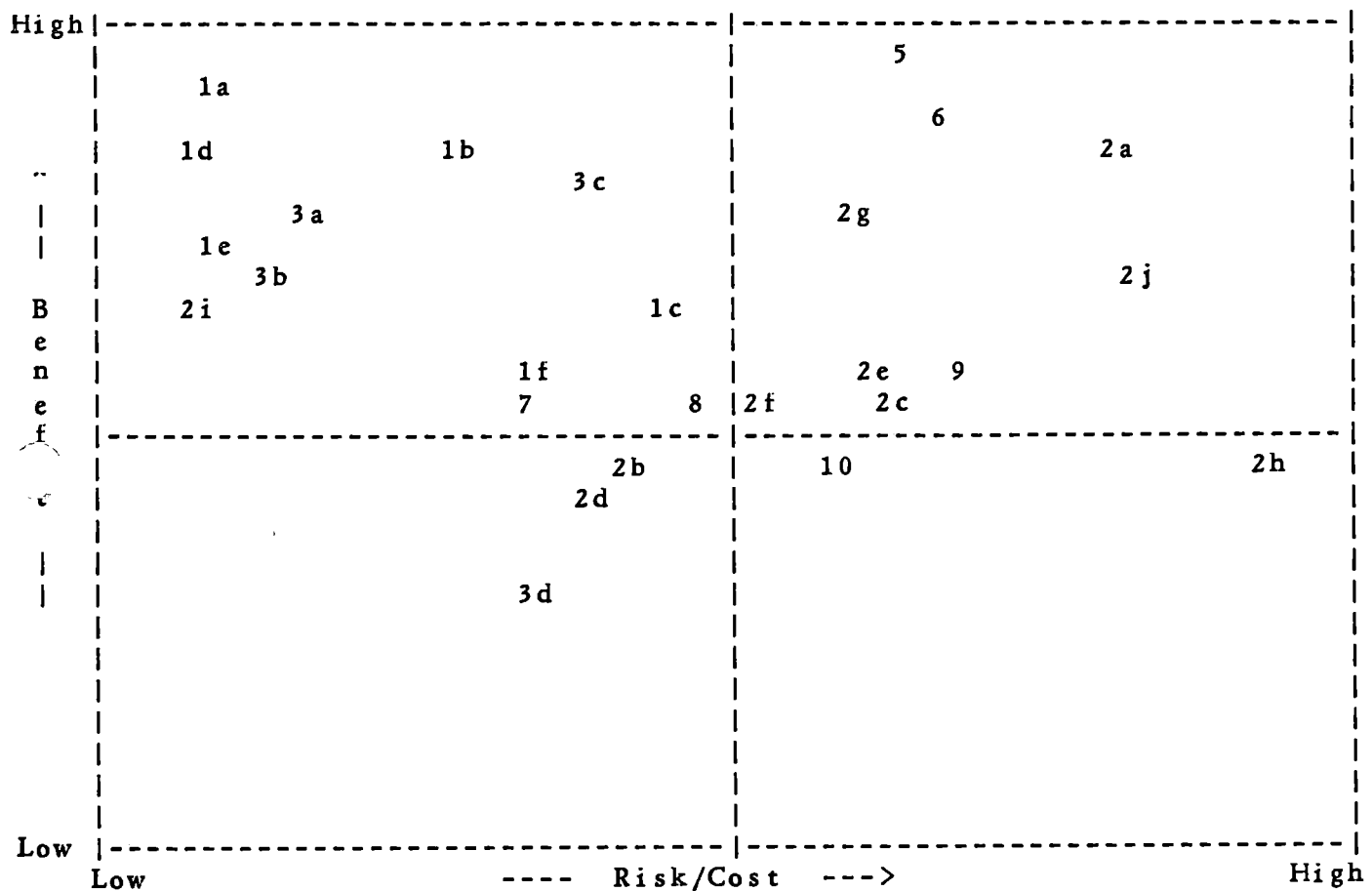
3. Change the conditions in the market.

- a. Help HCFA to develop its recommendations to Congress to bring rehabilitation services (presently excluded) into the Medicare Prospective Payment System.
- b. Work with Texas State agencies and legislators to help improve the legislation, regulations and resources that affect availability and financing of quality rehabilitation services for Texans.
- c. Keep THFC hearing officers current on the facts of rehabilitation (e.g., need, demand, and resources) by presenting expert testimony at appropriate hearings.

d. Catalyze the association of similar rehabilitation facilities into an affiliation like the Voluntary Hospitals of America.

4. Position ourselves for possible future entry into the rated tax-exempt debt markets.
5. Concentrate on providing high quality rehabilitation results at lowest cost to the purchaser over the long term (rather than lowest cost in the short term) and on establishing that niche in the market and repositioning the competition.
6. Re-organize the corporate structure to provide the business flexibility needed to seize the opportunities that present themselves. *Work with selective representatives and other staffs to increase federal and state funds of rehab re + self program.*
7. Establish formal relationship with a Department of PM&R at UIMSH before anyone else.
8. Catalyze the creation of a self-sustaining alumni support group of Texas SCI patients like the Texas Head Injury Foundation.
9. Obtain and maintain the position (for the appropriate legal entity) as the number one and most productive rehabilitation research group in the five-state region.
10. Grow now in order to recruit and acquire commitment of limited quality staff before competition enters the staff market.

Strategy Preference



Numbers correspond to the numbered strategies, and are intended as examples. A Delphi approach will be used to obtain our preferences after discussion of each strategy and after the relevant strategic business units have been outlined.

OPPORTUNITIES

1. For the first time in history, rehabilitation is an attractive venture financially. Being experienced and knowledgeable, we can acquire or direct some of the resources into areas long of interest to us.
2. The thawing toward free competition that the PPS has brought to the health care system by DRG payment and by exemption of rehabilitation services lets us establish relationships heretofore difficult to achieve. Creative financing, organizational structures and business plans are possible and commonplace now, and will continue for several years, until things stabilize into the best feasible resourcing arrangement under the new reimbursement methodology.
3. New entries in the rehab field will need help to set up and operate rehabilitation services. Training and upgrading will be required.
4. We presently have unused physical plant capacity for inpatient and outpatient programs.
5. We have regulatory approval to grow. We already have a CON. Others don't (yet). We can build up to 192 beds, even a complete replacement facility if we can finance it.

6. There is time to expand, consolidate and protect our market position. It will take over a year for most new entries to secure a CON, build, staff and market another facility.
7. There is unmet need for rehabilitation services in patient groups we don't presently serve. Diversification is possible.
8. New entries in the market (both investor-owned and not-for-profit) have proposed combining our expertise with their financial resources in joint ventures, management contracts, and consulting arrangements, to help create the required array of rehabilitation services in this community.
9. There is a need for education. Seminars, short courses, self-study courses, and "internships" will be necessary for emerging rehab programs at other sites.
10. There is a time window of 12-18 months before new facilities can be built or substantially converted due to CON and construction delays.
11. The health facilities planning law in Texas informs us of competitive plans and allows us to file as parties to any CON applications that affect us adversely, or for which there is clearly no demand, and to offer testimony to the Commission that affects their findings of fact.

12. There is an incentive for the major rehab facilities to cooperate and associate (with due attention to anti-trust laws).
13. High tech medicine, increased survival rates from trauma, an increasing number of persons over 65 with major disability and with chronic disease is increasing the need for restorative and rehabilitation services.
14. There is a growing need for transitional care (home care, congregate living), as well as long-term custodial care.
15. Some programs of our competitors are vulnerable to an alternative entry with a different focus and approach.
16. We are aware of no pediatric rehabilitation program in the area, other than our small one.
17. Baylor's PM&R Department has the potential to operate several bed services here.
18. We can collaborate with the University of Texas, Rice University, University of Houston, Texas A & M University, and others in programs of mutual interest and benefit.
19. New funds are available from the private sector.
20. We can fill a gap that now exists and increase

deinstitutionalization and independent living.

21. Former patients may be organized into alumni supporters.
22. We have new board members and new board leadership. They may become more involved in the mission.
23. We are generating internal funds that can be used to finance new ventures.
24. Local businesses are now following the national trend and are increasingly aware of the return that is possible on an investment in rehabilitating their workers compensation claimants and returning them to work. They will need guidance and resources to do so.

THREATS

1. Until rehabilitation becomes reimbursed on a prospective basis by Medicare, financial incentives of the Medicare Prospective Payment System (and present exemption of rehabilitation from the PPS) will decrease acute hospital occupancy, leading them to reclassify beds into rehabilitation units to escape into these cost-reimbursed segments of care.
2. There is, and will continue to be, significantly lower pressure for the acute hospitals to refer their patients to a rehab facility. Indeed, the incentives are to start rehab units and transfer patients there if reimbursement is improved thereby.
3. Entrepreneurs, as well as non-profit and for-profit chains will aggressively enter the rehab market with new facilities quickly designed, built and marketed following the (perhaps temporary) reimbursement incentives created (unintentionally?) by HCFA when they exempted rehab from the Medicare PPS. *MCN*
4. New entities into the rehab services market will compete for already limited professional resources. Shortages exist now, and are projected to 1990, for ~~PM&R~~ physicians, physical and occupational therapists. The supply of exceptionally qualified medical and other professional experts is even worse.

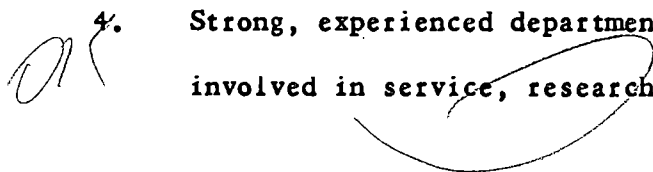
5. Regardless of our quality and cost, new entries into the market will reduce, perhaps temporarily, our share of certain markets, as some payors try out a new facility with no track record of results, especially if costs are lower. This may seriously reduce the volume and revenues of our present programs.
6. Need for rehabilitation services may exceed present capacity, but demand (the ability to pay for services to satisfy the need) of some financial resources appears to be close to present capacity. State agencies, (CCS, TRC) still run out of funds periodically. Their budgets are not likely to expand in proportion to proposed entries of new capacity into the market, leaving smaller slices of their reimbursement pie. These state agency funds are often used to complete the funding package for rehabilitation services for given patients).
7. Successful prevention programs (automobile crash restraints, DWI deterrence) should reduce the incidence of new spinal cord injury patients. This may not be totally offset by increases in injury due to smaller, lighter cars, failure to use restraints, and population growth. SCI cases constitute 75% of our volume.
8. Our small size, specialty nature, and short history of excellent financial performance may restrict our access to sufficient capital to do the things we need to do to compete.
9. At 95 beds, our size and volume has been too close to our break-even point for this patient and service mix, and we have been too

sensitive to changes in volume. At 115 beds we are in better shape, but must grow further to reach a conservative operating point. Limited capital access may prevent this.

10. We are too dependent on a few key physicians, the loss of any one of whom (or even their absence for vacation) significantly reduces hospital productivity and revenues. Projected shortages of key rehab experts to expand our physician cadre increase this risk.
11. Our specialization in apneic quadriplegia was affected temporarily by the unexpected loss of convenient, on-site access to our adult and pediatric pulmonary specialist physician. Other traditional professional consultation arrangements may be similarly revised unexpectedly as the effects of competition increase.
12. Loss of the single anesthesiologist could seriously curtail surgery and delay the medical rehabilitation program, or require increased transfers to acute hospitals.
13. Dallas Rehabilitation Institute is to open a 120-bed tertiary rehab facility 250 miles away in October of 1985. This facility is going to affect our catchment area, which we are going to have to expand beyond HSA-11 as we may experience some loss of market share for desirable patient populations. In 1983, we received ____ or ____% of our patients from the Dallas/Fort Worth metroplex.

14. By December 31, 1985, HCEA is to report to Congress a mechanism for including rehabilitation under the prospective payment system. It may not be one that recognizes fairly the complexity of care that our patient population requires. This could prevent efficient and effective delivery of rehabilitation services by limiting the variety of needed programs of service and the business models to provide them that are viable under the reimbursement system.
15. Not knowing what the reimbursement environment will be leaves us at risk of acquiring debt now and not being able to handle the debt service later. The new PPS system for rehabilitation or another reimbursement system (e.g., vouchers, all-payor) could adversely affect our ability to do business.
16. We are at risk of decreased volume due to bad publicity related to patient and family dissatisfaction with services, charges, and results.
17. ~~There are likely to be further cutbacks in~~ Federal grant funds for rehabilitation-related projects *may be curtailed.*
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TIRR STRENGTHS

1. Strong, visible, respected, and recognized program in spinal cord injury rehabilitation. Particularly recognized for excellent management of the apneic quadriplegic patient and patients with multiple trauma.
2. Small, but strong, visible program in amputee services.
3. Experienced, respected and recognized medical staff and consultants.
4.  Strong, experienced department directors and professional staff involved in service, research and education.
5. Dedicated and loyal staff.
6. Availability of a full range of needed services, surgical, medical, diagnostic, therapeutic, rehabilitative, managerial and technological resources, most on site, with others available in the TMC.
7. Established, long-standing linkage to the primary trauma centers in the HSA-11 13-county area.

8. Location in Texas Medical Center with strong linkages to and cooperation with other TMC institutions (image, service supports). The image and reputation of TMC and its constituent institutions is the highest. Outside health facilities cluster around it.
9. Located in large potential referral base (large, growing population center), community need for services.
10. Affiliation with a medical school (Baylor College of Medicine) that has one of the highest reputations in the country, and offers high quality support in every clinical area.
11. Historically, a national and international reputation for quality patient care, excellent results and beneficial innovations. Quality of care in the programs maintained by direct supervision of qualified senior physicians and experienced professional specialists.
12. Full accreditation by JCAH and CARF.
13. We know more about how to do quality rehabilitation than most groups in the region.
14. Long-established and continually improving relationships with payor groups and referrers in the region.
15. Twenty-five years of successful service and marketing to more than 30,000 patients and families from all states and 30 foreign countries.

16. "Graduates" of our residency programs, and our various educational and staff development programs become referrers.
17. A reputation for conducting excellent research and demonstration programs, with a history of certain recognized innovations in rehabilitation medicine, surgery, technology, and rehabilitation practice.
18. Innovation and application of technology (including high technology) is routine at TIRR. We are comfortable with it, we know how to innovate as well as apply it, and we have been doing it for years.
19. A large, intensive, leading edge research program in restorative neurology and clinical neurophysiology, privately funded, and international in scope.
20. Our Independent Living Research Utilization program is nationally recognized and effective, and links us into a wide network of resources.
21. Many of our staff occupy influential leadership positions in national, state, and local industry (AAPM&R, ASIA, ACRM, AAOS, NARF, IOM/NAS, CAREF, AHA, GHSC, AAP, etc), government advisory groups and consortia. We have been, and continue to be, involved in establishing various standards for the rehabilitation field.
22. Teaching programs in conjunction with universities and schools for health professions, locally, state, and nationwide.

23. Strong and involved Board Executive Committee and Board of Trustees, with effective linkages and relationships with the community representatives and access to resources.
24. We have not yet reached our potential in any area, and this keeps staff here and excited.
25. Alert, capable management team, experienced in and familiar with the rehabilitation field, and capable of moving the organization to its goals.
26. Excellent payor mix -- largely private, third party insurance (casualty and worker's compensation) with small (12% Medicare) cost payor base.
27. Recently completed new bed space, ancillary space, outpatient department expansion.
28. We have a certificate of need for additional capacity.
29. Historically high occupancy rates.
30. Most financial ratios better than industry standards.
31. Staff are ready for and will get excited about a clear direction for TIRR.

32. TIRR has an institutional reputation that may transcend the programs, and that may attract referrals to programs we offer.
33. We are involved in various forums that are developing recommending to HCFA an appropriate reimbursement mechanism for rehabilitation.
34. We own almost a whole city block of land outside of the Texas Medical Center at our annex site. Almost half the property is undeveloped, and has no covenants (like TMC property) that prohibit a build/lease back financing with investor groups.
35. Staff involvement with consumer groups.
36. Dedication and commitment of staff to a behavior and philosophy.

TIRR WEAKNESSES

1. Consumer orientation, market responsiveness, general business perspectives, relationships and practices do not yet sufficiently pervade the medical staff, management, and staff, and are increasingly necessary in the changing environment. Staff are slow to adjust.
2. Present full time medical staff are fully utilized and their number must be expanded in order to gain their participation in planning strategic business units.
3. Present management team must be expanded in order to develop new strategic business units.
4. The marketing effort is under-resourced, insufficiently coordinated, and inadequate for a competitive environment. Needs organization, direction, leadership and funds.
5. The patient care areas, with the exception of the recent remodeling and expansion, do not meet the expectations of today's patients, families, and referrers (even though their needs are met). Patient meals are criticized with respect to taste, variety, presentation and temperature.
6. Many ancillary services (OT, X-Ray, Pharmacy, RT) have unattractive space that is inadequate for additional service volume from the recent bed capacity expansion.

7. Land in the Texas Medical Center proper is rapidly being used, and while we have property available, our growth options are limited to what will fit on existing parcels, or requires demolition of existing structures.
8. Most of the TMC parking (for staff and patients) is distant from our building, and is considered expensive by some of our patients and family members, who see it as a barrier, and potential employees who see it as an employment disincentive.
9. There is not yet a comprehensive, shared, long term corporate plan, developed jointly, committed to, and guiding our activities and decisions.
10. There is uncertainty regarding the future of the Department of Rehabilitation at Baylor College of Medicine. Lack of strong Baylor support.
11. Our head injury program will not grow without energetic, aggressive leadership -- the team has not been pulled together.
12. Among some referrers, we are known by many for one patient type -- severely disabled complicated patients -- "our kind". We don't get many other kinds of patients -- moderate, or mild disabilities, non-SCI. This limits our ability to grow and ties our occupancy figures (and financial performance) to one patient group. When referrals vary, we have no significant alternate source of patients.

13. Five physicians are responsible for 90% of our volume. Loss of only one of them could severely affect our service volume and financial performance (and thereby our ability to service debt). This looks risky to the rating agencies, as well as to us, and limits our access to capital by reducing our creditworthiness. The five include the following:

<u>Specialty</u>	<u>Age</u>	
Internist	56	REC
Internist	44	LH
PM&R	43	W-D.
PM&R	48	S/M
Neurologist	62	RC

14. As a single small, specialized hospital, our access to capital markets, is limited. Rating agency judgments of our creditworthiness are determined in part by this fact, and additional expense (for letters of credit, insurance, and higher interest) is required if debt is to be issued.

15. Our successful financial track record is not sufficiently long to qualify for a favorable rating by a rating agency.

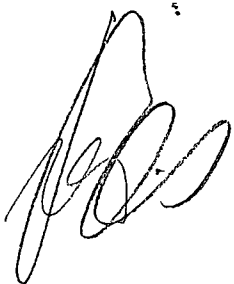
16. We need to arrange easy, daily, on-site access to an adult pulmonary specialist physician.

17. We rely, for most of our volume, on a single patient group, spinal cord injury. While this is a strength, it is also a weakness, in that it limits our flexibility. Competition in the spinal cord injury rehabilitation services market due to the PPS incentives and/or declining incidence of the problem due to successful prevention measures is likely to reduce our volume. We have not developed other markets to which we could shift.
18. We have to focus on teamwork at the management level. We have capable individuals who are not yet functioning smoothly as a team.
19. Our overhead has been too high for our revenue base. (See graph.)
20. In some areas, our service volume is inadequate to support essential backup staff.
21. We may lose patients due to delays in ascertaining the patient's financial ability to pay. Some factors we can control -- others we can only influence.
22. Our costs may be higher than others and we may lose market share if delays in handling patient equipment acquisition extend length of stay. We have not yet arrived at a satisfactory equipment handling methodology.
23. Our communication with inpatients regarding how they see the rehabilitation process, the staff, and the amenities, is inadequate in

that we do not hear about some problems until after discharge, if at all, and cannot correct them while the patient is here.

24. Our medical staff and hospital relationships with sponsors are not properly coordinated, resulting in inconsistent approach, understanding of concerns, and variable response, quality and timeliness, that strains our ties to these "customers" and costs us referrals.
25. Our treatment philosophy has been oriented primarily to an inpatient focus with outpatient service receiving low priority. The new incentives require an emphasis on reducing hospitalization and require a reversal of this approach which we have not yet achieved.
26. Uncertainty about the future, lack of agreed, long term goals, lack of clarity of the policy-making process, the desired management style and philosophy, and the clinical rehabilitation philosophy, and limited upward mobility lead to low energy, reduced morale, and staff turnover.
27. Variable, inconsistent feedback to referrers, patients and payors.
28. We have not systematized our quality promotion activities.
29. We have no corporate-level reportable statistics on outcome -- the results of rehabilitation -- that indicates the results of our efforts in an aggregate form and helps interpret to lay observers the benefits of the rehabilitation services we provide.

30. Research activities at TIRR have produced few salable products in recent years. We peaked over ten years ago with Harrington rod instrumentation, the Engen polypropylene brace, the kits for upper extremity orthoses (now marketed by Orthotic Systems, Inc.).
31. Our long history in the field may limit our creativity and willingness to break from tradition. Old methodologies may not serve us in a field where new entries are innovative. We are at risk of attempting business as usual when the tides are changing with such force that change is inevitable.
32. Appropriate functional relations among service, research, and education are only beginning to be understood and developed.
33. We have not established good mechanisms to have input into the State legislative process.
34. We lose some patients to follow-up.
35. We are not adequately active (or staffed) in disseminating materials or in training people in the region.
36. There is a lack of understanding of and appreciation for the roles of the various non-clinical departments.

 J. S. Waters

37. Inter- and intra-departmental infighting continues. Historical independence and long-standing balanced emphasis makes integration, coordination and cooperation difficult.

38. Board members have not been as active as we have needed.

39. Having been in existence for 25 years, we continue some activities, policies, attitudes and services that are not appropriate for circumstances today, and need redirection to meet current needs or pruning to free resources for new activities.

- 17/12 WHSLE PR. 200 -
- 19 COMMERCIAL TRANSPORTATION
 - 20 ^{UNIT} ~~RE~~MANAGEMENT
 - 21 RESEARCH & DEVELOPMENT
 - 22 IMPORT & EXPORT
 - 23 VOCATIONAL
 - 24 MINERAL BATH
 - 25 TRAVEL AGENCY
 - 26 INDUSTRIAL MEDICINE
 - 27 INSURANCE (HMO)
 - 28 TRAINING & SEMINARS (INSERVICE)
 - 29 ARCHITECTURAL ENGINEERING (ACCESSIBILITY)
 - 30 AADP
 - 31 ATTENDANT SERVICES
 - 32 DISCHARGE PLANNING
 - 33 MALL
 - 34 OTHER REHAB FACILITIES
- EVALUATION
- ns)

RET

RET

① DME

② SUPPLIES
(INCLUDING MAIL ORDER)

③ TESTING SERVICE

④ HOME HEALTH

⑤ REHAB ENGINEERING
(A) PRODUCT ① MATTRESS ④ PREEMPLOYMENT E
(B) CLINICAL ② ROBOT ③ FINGER JOINT

⑥ TRANSITIONAL LIVING

⑦ LONG-TERM LIVING

⑧ CASE MANAGEMENT

⑨ ORTHOTICS & BRACES

⑩ PROTHESES

⑪ CONSULTING

⑫ ~~CHALLENGE TRANSITION~~
PROGRAM CARE

⑬ DAY PROGRAM

⑭ MEDIA PRODUCTIONS (PUBLICATION
FOR REHABILITATION)

⑮ ~~OUTPATIENT~~ CORF

⑯ DRIVER'S TRAINING

⑰ SUPPORTED WORK

⑱ RESIDENTIAL