

STRATEGIC PLANNING IN ONTARIO ACUTE-CARE HOSPITALS:
A MIXED-METHOD STUDY

by
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A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Management in Organizational Leadership

UNIVERSITY OF PHOENIX

January 2010

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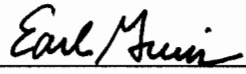
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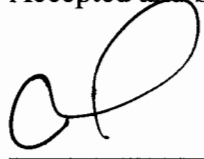
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ABSTRACT

The mixed-method study involved an exploration into strategic planning in the perspective of Ontario acute-care hospital leaders and the influence, if any, of strategic planning and hospital type on organizational performance within a new healthcare policy model. The research method for this study incorporated a two-stage sequential design: qualitative exploratory focus groups, and a quantitative empirical study. The results of the study indicate that hospital senior leaders use strategic planning principles inconsistently. Hospital leaders were largely unaware of organizational performance. No significant relationships were found between strategic planning, hospital type, and organizational performance. The analysis in the study led to a determination that acute-care hospital leaders in Ontario are unprepared to strategically plan within the new environment.

ACKNOWLEDGMENTS

The completion of this dissertation would not have been possible without the involvement of numerous individuals. I was blessed with the privilege of working with Dr. Jim Goes, my dissertation chair. His guidance, teaching, and most of all, patience were appreciated over the last three years. My committee members provided me thoughtful feedback and direction. My thanks to Dr. Earl Greenia, and special thanks to Dr. Bryan Poulin who mentored me throughout my doctoral journey. I also want to acknowledge and thank Dr. Michel Bedard at Lakehead University who kindly gave his time to assist me in developing my methodology, and Dr. Laurel Duquette at the University of Toronto who worked with me in the data analysis.

My research efforts were aided by Lou Reidel from the Ontario Hospital Association, who provided me with letters of introduction to Ontario acute care hospital leaders. I had the good fortune of working with, and drawing upon the expertise of four experienced past hospital administrators and board members as my expert panel. My grateful thanks go to Brenda Butters, Peg Hogarth, Hilary Short, and Sandra Kearne. Their honesty and frank discussions on their experiences in healthcare assisted me to create successful research instruments. I am also indebted to the hospital leaders who welcomed me to their organizations to discuss their strategic planning practices and piloted the survey instrument.

Before starting my doctoral journey, I asked my three children for their blessing. They knew how much I was at my desk when doing my master's degree and obtaining a doctorate would require even more sacrifice of 'mom time'. My deepest appreciation goes to Christopher, Catherine, and Matthew, for encouraging me to reach for my dreams

and supporting me in my goals for the past five years. My sincere thanks go to Ken Gehman, and Mary and Lamont Bergevin, who without their friendship and support, I could not have attained this degree.

I had a wonderful cohort of men and women who I worked closely with throughout my doctorate. As students, we were encouraged to find a classmate who would be a coach, mentor, and most importantly, a friend during the process of obtaining a terminal degree. Dr. Russ Darnall not only fulfilled this role, but he also helped me become a better writer, critical thinker, and scholar. Thank you, Catz, bunches, for everything you have done and for being you.

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CHAPTER 1: INTRODUCTION

Since 1996, the health-care system in Ontario, Canada has undergone significant change in terms of funding, accountability, organizational performance, and quality medical care delivery (MOHLTC, 2007a). What has remained unclear is how or if hospital administrators for acute-care institutions utilized strategic planning as a way of preparing their hospitals for government-imposed system changes. The purpose of the study was to examine strategic planning from the perspective of the hospital executive; did strategic planning occur and, if using strategic planning, was the strategic planning process different between hospitals based upon the type of hospital (academic, community, or small).

Included in chapter 1 is a discussion of the background of the Ontario health-care system and how the lack of understanding about strategic planning in this milieu required research. The chapter includes a discussion on the research methodology, population, and nature of the study. The theoretical framework reflected in the literature reviewed are an indication of how the research fits into the health-care strategic planning field, and include the relevance of the research questions and hypotheses. The chapter closes with an explanation of assumptions, scope, limitations, and delimitations of the study.

Background of the Problem

Historically, a virtual absence of research has existed on health-care strategic planning in Canada. As the Ontario government began implementing new methodologies designed to improve efficiencies and effectiveness (Ontario Legislative Assembly Local Health System Integration Act, Bill 36, 2006), it became important to understand strategic processes used in acute-care hospitals so that new policy applications were not

subject to outcomes of similar approaches in other provinces. Whether the members of government and health-care providers were approaching performance measurements with the same strategic mind-sets was uncertain. Despite numerous health-care reforms introduced by a succession of provincial governments, the achievement of performance targets did not occur, resulting in more reforms and increased accountability structures.

The burden of health-care costs on provincial budgets is overtaking the ability of the government to respond to other public needs. The 2007-2008 fiscal year allocation for health care in Ontario was \$37.9 billion in a total provincial budget of \$86 billion (Ontario Hospital Association [OHA], 2007a, ¶ 6). The Ontario government had allocated \$39.8 billion for fiscal year 2008-2009 and \$41.5 billion for fiscal year 2009-2010 (OHA, 2007a, ¶ 6). At the same time, citizens demanded improved services with the latest technologies without an increase in taxes. Since 1996, the number of acute-care beds in the province declined by 29% while inpatient admissions steadily increased and tallied over 1 million (Canadian Institute of Health Information [CIHI], 2007, p. 3).

Since the Ontario provincial government introduced methods to stabilize the cost of health care while maintaining the level of services, hospital administrators must determine how to utilize the resources the hospital receives in the most efficient and effective manner. To meet the efficiency and effectiveness goals requires strategic planning by the senior management teams. Ontario is the only province that maintains independent hospital boards with the responsibility of ensuring the development of strategic direction. The hospital boards are not responsible for conducting strategic planning (OHA, n.d.); all strategic planning is the responsibility of the hospital

administrator (OHA, n.d.). All other provinces in Canada use a regional health authority to determine strategic planning for acute-care hospitals in their area (Hanlon, 2001a).

To gain a greater appreciation of the strategic balancing act that Ontario hospital administrators must undergo, a review of the health-care setting in the province is necessary. Included in the review is the organizational environment that exists, the funding and regulatory policy environment, and the introduction of the local health integration networks (LHINs), a regional overseer of health-care delivery. The importance of strategic planning within the acute-care hospital sector emerged by gaining a perspective of the various constraints placed upon hospital administrators.

Organizational Complexity and Turbulent Environments

Complex environments when examined organizationally are environments comprised of a variety of agents coupled through shared interactions toward common goals (Dooley, 2002; Lichtenstein et al., 2006; Minas, 2005). Child (1972) discussed environmental complexity and noted that unless environmental variability exists, and if there are adequate resources are devoted to measuring the various components of the complex environment, of itself, complexity does not contribute to uncertainty. The numerous revolutionary health-care policy reforms that have occurred in Ontario since the mid 1990s fit the context of the hyperturbulent environment (Meyer, Goes, & Brooks, 1993). Due to government reforms, whether all acute-care hospitals in Ontario had the capacity to measure environmental changes and had the ability to respond was uncertain.

When discussing degrees of turbulence, others can envision a continuum with clear and predictable environmental demands at one end and ambiguity and vague demands at the other (Friedman & Goes, 2000). As administrators strove to understand

performance expectations from the provincial government on an external basis, the administrators placed a constraint around change internally, restricting the ability to be flexible in responding to a rapidly changing environment. What drove the actions of the administrators to stabilize the environment, and the degree to which the administrators acted, was largely dependent upon the individual or collective perception of environmental uncertainty (Begun & Kaissi, 2004; Kumar & Strandholm, 2002).

Whether acute-care hospital executives perceived enough stability existed to plan strategically or whether they fell into emergent, intended, or imposed strategic behaviors was uncertain (Inkpen & Choudhury, 1995; Mintzberg & McHugh, 1985; Mintzberg & Waters, 1985). Emergent strategy is the “patterns or consistencies realized despite, or in the absence of, intentions” (Mintzberg & Waters, p. 257). Intended strategies determined by the organizational team and imposed strategies result from stakeholders external to the organization (Mintzberg & Waters). An imposed strategy results from external factors binding organizational behaviors through direct imposition (Mintzberg & Waters). Interrelationships with the government, new regional health managers, and additional stakeholders in the health-care process created an environment in which hospital administrators might not have been able to gather enough information to gauge their response to change.

Financing and Budgeting

Canadians strongly support government funding for health-care services and disagree with any suggestion to rationalize services or dismantle universality, where every Canadian has equal access to health-care services regardless of socioeconomic status or geographic location (POLLARA, 2003). Still, costs must remain within the

public health system. The historical approach of hospitals had been to provide health care at whatever cost (Y. Chan & Lynn, 1998). Hospital administrators have found it difficult to adapt to the new business-like approach (Y. Chan & Lynn). The new accountability agreements signed with the regional integrated health network eliminated the ability to secure further funding dollars by running deficits (Ministry of Health and Long-Term Care [MOHLTC], 2007c). Hospitals must produce and operate within balanced budgets (MOHLTC, 2007c).

Local Health Integrated Networks and the Ministry of Health

Traditionally, administrators of Ontario's self-governed hospitals had little interest in collaborative planning of health-care delivery services within a set geographic boundary. As a response, legislation created the LHINs in March 2006 to "improve the way health care services are planned and delivered across the province" (MOHLTC, 2006d, ¶ 3). The government transferred the responsibility of service agreements of hospitals and community agencies to the LHINs (MOHLTC, 2007b). Still, little research was available to show that devolution of hospital accountability from the government to a regional health authority would result in improved community service efficiencies (Lomas, 1997; Lomas, Woods, & Veenstra, 1997; Maioni, 2004; Sinclair, Rochon, & Leatt, 2005). As the role of the Ontario LHINs was still evolving, hospital administrators were uncertain of the expected relationship between LHIN regional strategic planning and the strategic planning that evolved from the hospital senior management (Hanlon, 2001b).

Performance Measurement and Accountability

A system-wide hospital performance system did not exist in Ontario until the late 1990s (Y. L. Chan & Lynn, 1998). In 1998, the MOHLTC introduced a balanced scorecard system (G. R. Baker, Anderson, et al., 1998; G. R. Baker et al., 1999). The balanced scorecard system (Kaplan & Norton, 1992, 2001) combines a measurement system with strategic planning and management into a tool for organizational leaders to develop strategic formation and implementation. No evidence indicated acute-care hospitals consistently used the scorecard (Yap, Baker, & Brown, 2005) or if hospitals used the strategic planning to meet system-identified performance indicators. Under the new performance measurement systems and LHIN accountability agreements, MOHLTC (2007c) personnel introduced a variety of clinical and operational measurements.

Thus, research was necessary to examine whether Ontario acute-care hospital administrators actually undertook strategic planning, and if so, how they organized and executed the planning activity. By understanding whether strategic planning took place by acute-care hospital administrators and the methodologies used in the planning, policy and funding decision makers can conceptualize a health-care delivery framework within a regional setting. No previous formal analysis existed of Ontario acute-care hospital strategy. Greater understanding of established strategic planning methodologies employed by government officials and hospital administrators in this environment might identify additional strategy methods that will be more effective in reaching predetermined performance outcomes.

Statement of the Problem

Built on the philosophy of a single-payer system, administrators in the Canadian health-care system struggle to maintain an excellent patient-care system with limited financial resources (Evans, 2004). In the province of Ontario, changing demographics have produced and will continue to produce further burdens on hospitals to provide care to those who need it (OHA, 2005). Population projections for 2011 show a 17% increase of those aged 60 and over (Statistics Canada, 2005, Table 052-0004). An increasingly older and sicker population coupled with government reforms challenges hospital administrators' decision making in how to sustain acute-care services. The methods hospital administrators use to strategically plan for hospitals to provide patient services in these environmental conditions are not clear.

The Ontario government introduced reforms to encourage greater efficiencies in the system. Yet, little empirical proof indicated that hospital performance changed despite the reforms (Denis, 2004; Glouberman & Mintzberg, 2001a). In Canada, no research on hospital senior teams' strategic and decision making actions existed. Because no research existed on Ontario hospital administrators' strategic decisions, the effectiveness of government policy designed to achieve greater efficiency on an individual hospital basis was unknown. Significant knowledge was available on hospital strategic planning from a quasi-competitive focus encompassing multiple countries (Ginter & Duncan, 2000; Lim, Lee, & Kim, 2005), but no knowledge existed on hospital strategic planning from the single-payer system. Whether decision making was even strategic or if planning and decision making resulted in positive performance change remained unknown.

The study involved an investigation into strategic decision making and performance outcomes in 136 acute-care hospitals in Ontario. Several hospital leadership teams had merged into umbrella organizations servicing several hospitals; 114 acute-care leadership teams were surveyed. The mixed-method exploratory design used in-depth qualitative focus group sessions with four senior management teams to gain a greater understanding of the strategy and decision making process utilized by administrators in different types of hospitals. Using information gathered from the team sessions, the study involved developing and administering a quantitative survey to the senior management teams of acute-care hospitals in the province to gather information about the relationship between strategy, hospital type, and organizational performance. One senior hospital team piloted the survey design. For the purpose of the study, senior management teams had a designation of president or chief executive officer (CEO), vice president, or executive director.

Purpose of the Study

The first purpose of the mixed-method exploratory study was to understand whether acute-care hospital administrators in Ontario used strategic planning, and if so, how the administrators used it and from which hospital type (academic, community, or small). Second, the study involved determining the relationships, if any, between strategy, hospital type, and organizational performance (financial current ratio, full-time nursing equivalents, and readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure) at the acute-care hospital level. Independent variables for the study were strategic planning and hospital type. The dependent variable was organizational performance.

The population of the study was all acute-care hospitals in Canada, and the study involved sampling all 119 acute-care hospital leadership teams in the province of Ontario. Senior leaders from four hospitals participated in the qualitative (Phase 1[P1]) focus groups, and one senior hospital team agreed to pilot the study. Senior administrative teams from the other 114 acute-care hospitals in Ontario received invitations to participate in the quantitative (Phase 2[P2]) portion of the study. The intent of the study was to understand Ontario hospital senior teams' strategic decision making processes. Strategy often has an association with intent. However, if defining strategy requires criteria of intent, then the researcher is reliant on examining perceptions of the actors and not including the behaviors exhibited while creating the strategy (Mintzberg & McHugh, 1985). If strategy relates to the realization of goals, then the potential exists to monitor empirically the rise and fall of strategies. The differentiation of *deliberate strategies* (intentions realized) from *emergent strategies* (patterns realized despite or in the absence of intentions) or *imposed strategy* (patterns resulting from external factors binding organizational behaviors through direct imposition) provided greater understanding of the phenomenon of strategic planning within the acute-care setting (Mintzberg & McHugh, p. 161).

To gain an understanding of what method(s) of strategic planning exist, an exploratory study involved blending research methodologies through a mixed-method study to create a holistic view of the problem (Creswell & Plano-Clark, 2007; Tashakkori & Teddlie, 1998). Because no researchers of existing studies had used interviews or surveys that identified the concept of strategic planning from hospital executives' perspective in a Canadian provincial health-care setting, an exploratory study was most

appropriate. Using qualitative data to create a quantitative instrument was a variant of the exploratory study method known as an *instrument development model* (Creswell & Plano-Clark, 2007, p. 77). The current research study included the development of a customized instrument to measure performance via strategy (see Appendix A for survey prototype).

Significance of the Problem

Provincial governments in Canada try to provide quality health care to patients while controlling the spiraling cost of providing such care (OHA, 2007a). A greater understanding is required to determine if government leaders necessitated constant reforms in the acute-care system because hospital leaders did not strategically plan to meet required performance expectations. Health-care management teams are accountable to multiple stakeholders, namely the government, boards of directors, LHINs, and the community. In response to the expectations of stakeholders, the senior management team provides leadership to the organization meeting the hospital mission of patient care, while at the same time showing fiscal responsibility in the use of taxpayer dollars. Using strategic planning, hospital leaders seek creative and innovative methods to create efficiencies in the system and effectiveness in patient-care models. Implications of not using effective strategic planning methods and processes leaves hospital leaders and their boards open to additional system reforms and censure by LHIN administrations and the Ministry of Health and Long-Term Care.

The study involved determining if hospital executives used successful strategic planning methods, and the study results revealed whether organizations developed best practice methods to meet and satisfy strategic goals. Study results indicated that hospital

executives were having difficulty in planning strategically. Variables that contribute to the lack of planning success provide direction to hospital leaders, government, and hospital organization officials where improvements are necessary to meet expected performance measures. The distinctions are important to understand; stakeholders might place blame on the lack of organizational performance on deficient leadership instead of on the scarcity of planning resources. The study involved generating recommendations that in time could lead to stronger and more effective strategic planning in provincial hospitals.

No prior research existed in any Canadian province on the practical application of strategic planning in the health-care system. Use of performance measurements as an Ontario system-wide approach is not uniform across the acute-care hospitals, and is still a relatively new concept to the hospitals (Yap et al., 2005). Although personnel at CIHI collect data nationally using various indicators to measure hospital performance, some loopholes exist that permit certain hospitals to avoid submitting numerous clinical indicators (Statistics Canada, 2006). Monitoring peer hospitals and the hospital's performance in relation to other hospitals of the same size and service provision is difficult. Whether hospital administrators are planning strategically or simply reacting to threats and opportunities as the threats and opportunities appear is difficult to determine. Whether the hospital administrators have a clear understanding of provincial expectations in meeting predetermined performance measures or whether the administrators possess the tools required to perform such a role also remains unknown.

Significance of the Study to Leadership

Hospital administrators must bridge the expectations between government policy makers, patient and community interests, and the requirements of health-care providers (Brown, Alikhan, & Seeman, 2006). If the research results had showed hospital administrators had an understanding of the anticipated goals and yet were unable to reach goals, the question arose whether leaders have the competencies to implement change in an efficient and effective manner. If leaders did not have the knowledge base necessary for effective strategic planning and implementation, then this information is important as the new regional health networks expect that hospitals leaders understand and implement strategic planning effectively.

The concept of using strategy to move an organization forward requires organizational change, which is transforming. Individuals who exhibit behaviors that lead the change movement demonstrate leadership that is both strategic and transformational. Child's (1972) work on strategic choice reflected that decisions that influence the perception of the organization, evaluation of the organizational structure, and how the organization responds to its environment might come from a variety of sources other than economic determinants. Hambrick and Mason (1984), in their germinal work on upper echelons, contended that to that point in time, the focus of literature was on the management skills of top management teams; researchers did not discuss leadership components as important contributing factors to organizational success. Within the Ontario health-care setting, it remains unknown whether current behaviors of hospital senior management teams constitute organizational leadership or merely demonstrate acquired management techniques.

Nature of the Study

The study involved an examination of strategic planning, hospital type, and organizational performance from the hospital administrators' perspective with each hospital as the unit of analysis. A deficit exists in the literature on strategy within provincial health-care systems, resulting in a lack of understanding of what or how strategic theory application took place within the Ontario acute-care environment. Because the study's design was to determine whether generalizations were identifiable in Ontario acute-care hospital strategic planning for use in hospital–government relationships, the research was pragmatic in viewpoint and pluralistic in nature.

Measuring strategic planning and organizational performance required an exploration of the subject matter from the perspective of those who performed the task to gain a greater perspective of the field from their lenses. To this end, a mixed-methods research design was the most appropriate for the study. To determine if correlations existed between strategy, setting, and performance, more than a straight qualitative method was necessary. It was difficult to validate a purely quantitative approach to explain the relationships between strategy and performance, as there was no existing strategy research on Ontario acute-care hospitals.

Researchers in multiple studies have researched strategy in the health-care environment (Byington, Keene, & Masini, 2007; Cueille, 2006; Ginter & Duncan, 2000; Goes & Park, 1997; Hemmasi, Graf, & Williams, 1997; Newhouse, 2007; Trinh & O'Connor, 2000). In most cases, the researchers had studied acute-care hospitals that received payment through a variety of payers versus the single-payer government-sponsored organization (Blair et al., 2002; Topping & Malvey, 2002; Wilcox King &

Ziethaml, 2002). Although acute-care hospitals are present across Canada, the focus of the study was the population of Ontario acute-care institutions. Included in the study population were 13 academic and teaching institutions, 53 community hospitals located in urban centers, and 70 small hospitals primarily located in rural areas (OHA, 2007b), for a total of 136 hospitals. Several small hospitals across the province had consolidated their senior management teams, and the number of senior management teams surveyed was 119.

Because the context of the research had unique components, the study included instruments specific to the study parameters. The study involved the use of a sequential exploratory study to study the population of hospital administrators. An inductive approach using a purposeful sample to describe the behaviors in strategic planning through a focus group process was appropriate as a first step (Slater & Atuahene-Gima, 2004). Using relevant literature and information gathered from focus group sessions, a deductive approach followed with a survey to measure statistical relationships between strategy, hospital type, and organizational performance.

The first phase of the study was a qualitative exploration of the strategy process as viewed by senior hospital management teams. Four senior management teams representing different hospital types (academic, community, and small) participated in focus groups to understand how the administrators viewed the strategy process. Interviewing all senior team members helped to reduce responder bias (Creswell, 2003b). The type of microstrategy that involved examining the conception of strategy from the participants' viewpoint in detail gave a greater appreciation of the decision making processes (P. S. Barr, 2004).

Using themes derived from the qualitative data and supportive theoretical literature, the second phase of the research involved a quantitative instrument. Administrators in acute-care hospitals in the province of Ontario received a researcher-created Likert-type survey (see Appendix A for prototype) to relate strategy and organizational performance with controls of hospital type (academic, community and small hospitals differentiate according to size, patient acuity, and funding levels). Excluded from the survey were the hospital administrators involved in the qualitative sessions and piloting of the quantitative survey. An understanding of the relationships was critical to determining whether provincial regulatory reforms resulted in positive hospital outcomes.

Research Questions and Hypotheses

Determining the best method to frame research questions for a mixed-method exploratory study is difficult (Creswell, 2003b; Creswell & Plano-Clark, 2007). The study included the use of a sequential study using a two-phase mixed-method approach. Hypothesizing relationships was difficult, as the instrumentation for the quantitative portion of the study was contingent upon the results of the qualitative phase. Within the order of the study, the information sought in the study was within the research questions. The design of research questions included exploring how hospital leaders from various hospital types may have used strategic planning to determine if certain administrators gravitated towards particular strategic frameworks.

The purpose of the research was to understand how administrators of acute-care hospitals in Ontario used strategic planning to meet population health-care needs and whether strategic planning and environmental setting of the hospital influenced

organizational performance (financial current ratio, full-time equivalent nursing positions, readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure). Since the MOHLTC determines the delivery of healthcare services by hospitals, hospital types (academic, community, and small) reflect the size of the hospital, the patient acuity level, and geographic location. Creating the foundation involved breaking down the purpose into five questions:

1. What is the content and context of strategic planning from the perspective of hospital administrators and does strategic planning within this environment emulate other strategic planning methods or theories?

2. What do hospital administrators view as best practices in strategic planning (presuming that the planning takes place)?

3. What differences in strategic planning and views as best practices to achieve performance goals exist between types of hospitals (academic, community, and small)?

4. What is the correlation, if any, between strategic planning and hospital performance in Ontario acute-care hospitals?

5. Which types of hospitals perform better than others and which, if any, of the three strategic planning principles (environmental scanning, strategy formation, and implementation) are used?

Based upon the literature review and historical evolution of the Ontario health-care system, the design of the research was to answer three preliminary hypotheses. The hypotheses referred to the existence of an identifiable strategic planning framework, results of such a framework with regard to organizational performance, and if hospital type (academic, community, and small) had any influence on organizational performance.

An identifiable strategic planning framework has a specific planning process (Mintzberg, 1994) that could be unique to the type of hospital involved; however, specific steps taken within the process might capture the movement toward reaching goals (Research Question 5). The first hypothesis explores whether relationships exist between strategic planning frameworks and hospital type.

H1₀: Hospital type (academic, community, and small) is not related to use of an identifiable strategic planning framework.

H1: Hospital type (academic, community, and small) is related to use of an identifiable strategic planning framework.

To determine whether the strategic planning or hospital type affected hospital performance as well as the dependent variable, questions in the second and third hypothesis (as reflecting Research Question 4) questioned whether the interaction of hospital performance (financial current ratio, full-time equivalent nursing positions, readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure) differed between strategic planning and hospital type.

H2₀: Hospital type (academic, community, and small) is not related to hospital performance.

H2: Hospital type (academic, community, and small) is related to hospital performance.

H3₀: There is no relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

H3: There is a relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

Support or revisions of the preliminary hypotheses were dependent upon the data gathered from the qualitative research.

Theoretical Framework

Strategic planning in the Ontario health-care environment is complex. Numerous decision makers exist within the strategic context, including external government policy makers, independent boards of directors, and internal physician stakeholders. When planning strategically, uncertainty existed regarding whether any collaboration or consideration of the various strategic needs of stakeholders occurred within the acute-care health continuum (Carney, 2004). Other constructs such as the type of hospital, the vision and goals of the organization, and what administrators felt were strategic planning best practice methods added to the number of options that administrators chose from when strategically planning. The complexity of the environment favored the use of multiple strategic theoretical concepts that would illuminate difficulties that hospital administrators faced when planning for their organization (Glouberman & Mintzberg, 2001a). The permutations of strategic components resulted in hospitals displaying different strategic behaviors that were not successful in meeting organizational performance expectations (see Figure 1; Brown et al., 2005).

Strategy

As Mintzberg (1978) noted, strategy is traditionally an explicitly constructed, purposeful plan designed in advance to meet anticipated actions within the environment.

Mintzberg (1978) noted that this definition of intended strategy would be reasonable if the environment was stable or predictable and strategic planners fully informed of all eventualities the organization faces. In a more turbulent and complex environment, Mintzberg (1978) contended that strategic planning could not be a priori; instead, many organizational decisions were bereft of premeditated thought. In the case of Ontario hospitals, rapid, recurrent government policy changes increased the uncertainty that administrators faced (Cameron, Kim, & Whetten, 1987), increasing perceptions of turbulence.

An emergent strategy evolves as an organization learns and adapts to the environmental pressures around it. An imposed strategy results from external factors binding organizational behaviors through direct imposition (Mintzberg & Waters, 1985). The Ontario government determined the format under which Ontario hospitals operate (Ontario Legislative Assembly Ontario Health Care Services Act, Bill 94, 1985). With the introduction of the LHINs, additional oversight bodies contributed to the direction that hospitals receive on a regulatory level. Policies were “tentative theories about the nature of social processes and the working of social institutions” (Majone, 1975, p. 50).

Policy can also create logical impossibilities in that it is impossible to maximize the benefits of a certain action while concurrently minimizing the costs of performing that action (Majone, 1974). If government policies created a policy that is impossible to transfer to application, yet the hospital administrators were required to implement the policy, how this affected the strategic planning process or the ability to meet organizational performance requirements was uncertain. Whether government policy makers had the experience and expertise to understand the nature of acute-care

institutions and the means by which the hospitals carried out their work remained uncertain.

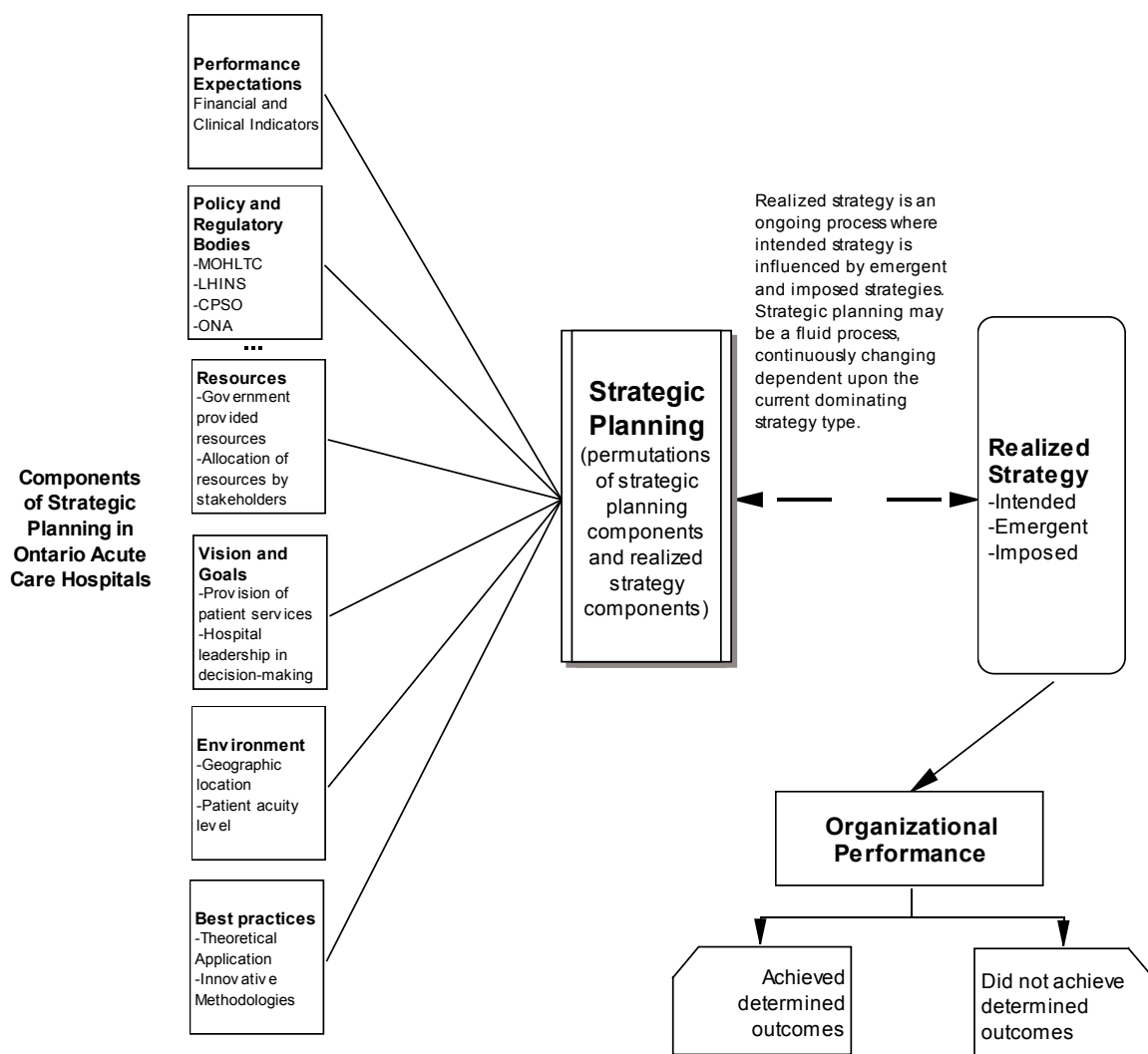


Figure 1. Available components of strategic planning in the Ontario acute-care environment.

Many of the traditional external environment segments related to competition and profitability usually found in strategic planning have been missing in the Ontario health-care system (Y. L. Chan & Lynn, 1998). It was only since the mid 1990s that the government had pressed hospital administrators to start viewing hospital management

with a business perspective (Y. L. Chan & Lynn). Various performance indicators had appeared and disappeared since 1996; funding formulas and expectations to receive funding changed regularly (Pink et al., 2001). The organizational design of Ontario acute-care hospitals was not a business model, despite the expectation of the government; as a consequence, the ability to adapt internally to rapid change was difficult.

Government-stratified performance measurements depend upon hospital type (academic, community, and small) (MOHLTC, 2007b). Yet policy makers when creating performance benchmarks did not consider geographic area or specific internal and external influences (MOHLTC, 2007b). As acute-care hospitals existed in a variety of locations with multiple different variables determining resource availability, the strategic outcomes for each hospital were unique to the hospital itself (Bourgeois, 1980). Under what format strategies developed in the Ontario hospitals was unknown. The impact of the permutations of strategic components with the strategy types upon organizational performance was unclear. Whether clustering of organizations based upon common organizational design elements into strategic groups was possible also remained unknown, as had been found to happen in other industries (Hatten, Schendel, & Cooper, 1978).

Organizational Adaptability

A discussion on organizational adaptability or flexibility usually includes the creation of organizational efficiencies using innovation systems and interorganizational cooperation (Staber & Sydow, 2002). The interorganizational cooperation moves through specific stages of adaptation to changing environmental conditions (Ring & Van de Ven, 1994). Miles and Snow (2003) described differentiations in organizational capacity in a

typology of organizational strategies from organizations with low adaptive capacity (reactors) to organizations with the highest adaptive capacity (prospectors).

McKee, Varadarajan, and Pride (1989) noted that the characterization of adaptation was “deliberately inefficient” (p. 21) because efficiency had an association with specific activities with little variation in practices. Many organizational leaders who operate in turbulent environments seek efficiencies by associating with set rules and boundaries that maintain standard management practices. Weick (1979) noted that organizations operating in niche markets might be unable to adapt to change. Bourgeois (1980) claimed that organizations with a resource cushion or organizational slack had the potential to adapt to internal and external pressures using changes in strategy.

In the case of Ontario hospitals, rules and boundaries extended beyond government policy to other regulating bodies. Organizations such as the College of Physicians and Surgeons required specific behaviors of physicians practicing medicine, which affected the management of the hospital (College of Physicians and Surgeons of Ontario, n.d.). How the dependency upon the regulating bodies for organizational legitimacy and resource availability influenced the ability to plan strategically or how the hospital leaders accepted imposed strategy remained uncertain.

Depending upon the level of adaptive capacity, organization administrators use feedback from the environment to make internal structural changes. The extent to which organizational leaders develop adaptive capacity reflects the organization’s ability to respond to environmental change. McKee et al. (1989) found that leaders in volatile environments chose deliberately to reduce adaptive capability. Organizational leaders with limited adaptive capacity seek solutions reflecting current organizational

competencies. In more stable environments, organizational leaders with a high adaptive capacity wander in their ability to develop a strategic orientation in an effort to be responsive to environmental change.

Some adaptation theories are not concerned with creating and managing the adaptive capacity of organizations since the focus of the theories is finding optimal solutions under current conditions (Staber & Sydow, 2002). According to Staber and Sydow, “Adaptive capacity aims less at improving economic efficiency than improving the ability to learn, to act reflexively, and to maintain or transform social structures and processes” (p. 412). Regulatory restrictions limit changing many processes within the acute-care environment. Hence, high adaptive capacity was less likely to be evident in the Ontario hospital environment.

The Ontario Hospital Model

Several approaches to strategic planning exist. The majority of approaches contain the three principles environmental scanning, strategy formation, and implementation (Jennings & Disney, 2006; Kaleba, 2006; Zuckerman, 2003). Because health care is a provincial government mandate by law, strategies in the Ontario context related directly to the public policy and regulatory environment as conceptualized at Queen’s Park (Ontario Parliament, Toronto, Ontario; Ontario Legislative Assembly Ontario Health Care Services Act, Bill 94, 1985). Hospital administrators were subject to multiple different theories and ideas concerning strategy development and how to create efficiencies and improved performance outcomes (Begun, Zimmerman, & Dooley, 2003; Scott, 2003). Within the acute-care environment, adaptation contingency theories were appropriate to explain the congruence between the demands of the external environment

(macrocongruence) and the internal environment (microcongruence) and to offer solutions on developing efficiencies (McKee et al., 1989). In the environment of the Ontario acute-care health-care system, the macrocongruence theory most applicable was resource dependency, and the microcongruence theory was resource allocation. The theories helped to understand actions of the hospital administrators during times of conflicting demands placed upon health-care administrators.

As reflected in Figure 1, the regulatory environment of government and professional bodies placed contingencies and restrictions on the availability of resources to acute-care institutions. External regulations are components senior administrators might consider when developing strategic plans. While the LHIN administrators approve or reject budgets set by the acute-care hospitals, hospital administrators must also satisfy important internal stakeholders, primarily physicians and nurses, who utilize the resources to provide patient care. Resource allocation theory reflects the internal group's ability to utilize resources that might or might not affect organizational performance. Examined in the research was whether strategic frameworks created by acute-care administrators reflected components outlined in the theories. The controls set by external resource contributors (resource dependency) or internal resource users (resource allocation) contributed to whether strategic planning was intended, emergent, or imposed, and the impact upon organizational performance.

Resource Dependency

Institutionalization has many similar qualities as resource dependency, such as an external body or bodies constricting the use of resources to the organization. The interlocking and interdependencies of organization creates control or power relationships

that increase the ability of the external body to coerce organizations into actions not otherwise considered (Palmer, 1983; Stigler, 1971). Resource dependency theory states that the organization has relationships with multiple associations and is unable to separate fully from those organizations that control resources (Pfeffer & Salancik, 2003). In the case of Ontario acute-care hospitals, it is impossible to separate the professional and accrediting associations that integrate with and regulate hospital management from the government funding and policy makers. Additionally, resource dependency in the Ontario health-care setting is broader than the provision of funding. Resource dependency includes policies that dictate how hospitals may utilize the resources (capital and technological) available.

Goes and Park (1997) noted the resource dependency model was a prevailing theory on interorganizational linkages. Pfeffer and Salancik (2003) described how organizational decisions such as positional power and legitimacy satisfied external groups' demands for effectiveness in resource utilization. Resource utilization reflects the organization's awareness of internal and external environmental influences, resulting in behaviors demonstrating Weick's (1979) enacted environment. The interdependencies and conflict between the organization and the external groups arising from how resources can and will be allocated creates a certain level of uncertainty for the organization (Pfeffer & Salancik).

Resource dependency within the Ontario acute-care strategy model (see Figure 1) intersects in two ways. First, the provision of tangible resources through operational funds for the management of the hospital created interorganizational dependencies affecting strategy components utilized for strategic planning. Second, governments

generated resource dependency by outlining resource usage as political strategy to influence constituents. An example was additional funding for cancer surgery, joint replacements, or wait-time strategies (Hudson & Glynn, 2004). This form of resource dependency aligns with the imposed strategy type.

Resource Allocation

Like resource dependency, resource allocation includes multiple partners and multiple layers of influence. Where the two theories differ is that in resource allocation, external influences have reduced impact upon the allocation of resources and the strategic planning of use of those resources (Noda & Bower, 1996). The drivers of resource allocation are internal to the organization, and middle managers or comparable groups contribute significantly to strategic decisions and plans (Noda & Bower). In the case of Ontario hospitals, the physicians and nurses had power through the knowledge of patient care. Senior administrators did not necessarily have the patient-care knowledge base and were reliant upon the nursing and medical staff to direct the allocation of scarce resources.

The regulatory and professional bodies associated with an organization can provide direction for behavior and actions of organization members. Regardless, the influence does not necessarily extend to the behavior of all members of the organization as a whole. Thus, resource allocation initiatives by organizational members are not necessarily autonomous to the benefit of the organization (Christensen & Bower, 1996). The interference of regulatory and professional bodies through the influence of certain subsets within the organization encourages the misallocation of resources (Banks, Foreman, & Keeler, 1999).

Resource allocation influences the Ontario acute-care strategy model (see Figure 1) simultaneously from two directions. First, the dependency upon medical staff to designate resource need and usage motivated strategic planners toward specific resource allocation, frequently based upon individual medical staff priorities. Second, changing standards in professional requirements or perceived patient needs create emerging needs addressed within the strategic plan. For example, best practice methodologies revolving around technology drive a great deal of the allocation of resources. Medical-legal implications on the inaccessibility of resources compel strategic planners to consider constantly changing professional requirements and regulations.

As outlined in Figure 1, hospital administrators can utilize multiple components when developing strategic plans. How external organizations that provide resources and regulations create dependencies upon the hospitals and internal stakeholders such as professional bodies influenced the context and content of strategic planning. Because uncertainty existed regarding the combinations of strategic components in the planning itself, additional confusion existed on whether strategic planning was constantly evolving to realize strategies due to influences of imposed and emerging strategies. The planning component of strategic planning could be an oxymoron as external and internal relationships and dependencies compete against each other for resource availability and allocation. Depending upon the strategy type that evolves, the jostling of different priorities affects the overall organizational performance in meeting set goals. The double arrow in Figure 1 signifies the bidirectional relationships that strategic planning and strategy types could have on each other. No model on Ontario health care indicates whether a relationship exists between strategic planning and strategy types. Thus,

although an examination of the potential of this belief occurred, only a one-directional model (the effect of strategy on performance) was tested.

Definition of Terms

Adaptation. Adaptation is the outcome of managers using best practices to change reactively organizational strategies and structures to fit contextual conditions while maintaining internal interdependencies (Miles & Snow, 2003; Staber & Sydow, 2002).

Complex adaptive systems. Complex adaptive systems characterize numerous independent variables interacting in a variety of ways. Using nonevolutionary methods, complex adaptive systems self-organize to be respondent to environmental change (Glor, 2007; Holland, 1995; Kauffman, 1995; Waldrop, 1992).

Devolution. Devolution is the transfer of responsibility or authority from a centralized to a regional government or government body (Lomas, 1997).

Emergent strategy. An emergent strategy that forms though not formulated and a realized pattern that was not specifically intended (Mintzberg, 1994).

Imposed strategy. An imposed strategy originates from within the environment (Mintzberg & Waters, 1985). Environmental factors direct actions through either direct imposition or encroaching on organizational choice (Mintzberg & Waters).

Intended strategy. Intended strategy is strategy developed from formal plans with precise intentions (Mintzberg & Waters, 1985). Senior leaders develop and articulate strategy using formal controls to reduce risk in implementation (Mintzberg & Waters).

Organizational complexity. Organizational complexity is the amount of differentiation between various components that comprise the organization (Dooley, 2002).

Performance measurement. For the purpose of the study, performance measures are qualitative and quantitative data an organization uses over time to monitor required operational efficiencies and effectiveness (Pun & White, 2005).

Resource allocation. Resource allocation is the strategic process in which the strategic initiatives and priorities of middle and lower managers compete for scarce corporate resources and the senior management team's attention to survive in the structural and strategic corporate context (Noda & Bower, 1996).

Resource dependency. Resource dependency refers to the organizations negotiating with external bodies for the acquisition of resources (Pfeffer & Salanick, 2003). Control over resources provides the external body with power over the organization. The organization copes with environmental contingencies by continuously bargaining for needed resources.

Strategy. Strategy is the systemic method to determine and articulate specific premeditated actions, which are then implemented (Mintzberg & McHugh, 1985).

Strategic planning. Strategic planning formalizes processes; a fixed procedure dissected into specific steps supported by various methodologies (Mintzberg, 1994). Results are a fully designed plan then incorporated through organizational functional areas within the organization (Mintzberg, 1994).

Turbulent environment. A turbulent environment is a dynamic process that creates uncertainties for organizations (Emery & Trist, 1965).

Assumptions

The study included several basic assumptions. The first was that based on knowledge of the acute-care environment in the province of Ontario, hospital

administrators were active participants in developing the strategic plan. The assumption was reasonable because hospital administrators were responsible for accreditation purposes to have a strategic plan in place.

The second assumption was that all respondents would answer honestly to questions. Informing hospital administrators that information learned from the questions in the sessions and survey would be returned to the hospitals and the OHA for use in further improving strategic planning within the acute-care hospital environment encouraged honest dialogue. Questions in focus group sessions centered on the perceptions that administrators within their capacity had to meet desired objectives and not on the actual performance. Another assumption was that the proposed interview questions and survey items would adequately capture major dimensions of the strategic planning literature. The assumption was reasonable because of the breadth of literature consulted and applied to the creation of the questionnaire and survey content.

Scope

The study was confined to surveying acute-care hospitals in the province of Ontario. While designed to capture a sizable population of the senior acute-care hospital administrators and thereby enhance generalizability within the Ontario acute-care environment, the relevance of the study to other acute-care environments in Canada is limited due to the differences in each province in the organization and administration of health-care delivery. Ontario is the only province where responsibility for strategic planning resides with the hospital administration. The results from the research, as a consequence, have limited generalizability to other provinces.

The focus of the exploratory study was on the hospital administrators' conception of strategic planning and hospital performance. To minimize bias, the qualitative phase of the study was limited to southwestern Ontario, where no personal relationships existed with any members of the senior management teams selected for the qualitative component of the study. The sample performed health care in an environment that experienced resource availability different from other sections of the province. Southwestern and southeastern Ontario are heavily populated with cities and communities in close proximity and a large number of academic and community hospitals within a few hours of each other. This is unlike northwestern and northeastern Ontario, which have no academic centers, have one or two tertiary-level hospitals, are rural, and service large geographical areas. Organization of each of the 14 LHINs in the province of Ontario is slightly different. The organizational differences might have influenced the strategic planning behavior of the hospital administrators in that section of the province and thereby limited the generalizability of the results.

Limitations

The study had several limitations. The study was limited to the willingness of senior hospital management participants to provide honest and open information in a focus group setting and the willingness of survey respondents to provide honest answers. Both the qualitative and the quantitative phases of the study were restricted to members of the senior administration team with the title of CEO or president, vice president, or executive director, which was limiting to the research as other internal stakeholders could have had significant influence on the strategic planning of the hospital. Professional relationships held with hospital administrators within northwestern Ontario could have

contributed to researcher bias when examining results from different hospital geographical areas.

The qualitative phase of the study involving focus groups of hospital administrators was limited to one geographical location of the province: southwestern Ontario. This was limiting to the research as hospitals in other geographical locations might have had different resource needs and capabilities. The study included the use of a theoretical model based upon observation and existing resource strategy theories and did not empirically validate an identifiable strategic planning framework in the Ontario acute-care hospital environment.

Focus group questions might not have been adequately specific for participants to have captured salient context of strategic planning. To understand the actual types of strategic planning used, it was necessary to keep the questions as broad as possible. The study involved the use of a cross-sectional method and was not a longitudinal study, which could better measure strategic planning performance over time. As the funding formula for acute-care hospitals had changed since 2007, previous relationships of resources to strategic planning were not equitable to current government expectations of hospital performance. Time constraints to complete the study did not allow a longitudinal study.

Using a qualitative thematic context to develop quantitative survey questions could have resulted in missing significant components of administrators' strategic planning. Reviewers from the expert panel and an acute care hospital examined the results from the qualitative phase to ensure the capture of strategic planning components in the quantitative survey. Measuring efficiencies in a specific instrument was difficult

because the measurements required by the MOHLTC were not universal to all acute-care hospitals in the province. Narrowing the focus of what factors could be included in the instrument could weaken the ability to determine whether significant relationships existed between strategic planning and performance. The survey instrument identified hospital type to have the ability to remove certain hospitals if necessary to achieve valid results.

The use of a survey to capture information was limiting because different interpretations of specific concepts could occur on multiple levels. All prospective participants were sent a glossary of terminology to minimize the variation of definitions (see Appendix B). As the study involved an attempt to understand specific concepts of strategic planning, the survey might not have captured multiple indicators of variables, especially because different hospital types captured variables on different levels.

If only certain types of hospitals responded to the survey, this would have skewed responses and in turn affected the ability to obtain accurate data on a provincial basis. A letter from the OHA asking all acute-care hospitals to complete the survey was attached to the request for participation in the research. The sample was also checked for representativeness of the population.

Delimitations

The use of several delimitations served to narrow the scope of the study. Although acute-care hospitals exist throughout Canada, only hospital administrators in the province of Ontario participated in the study. Unlike other provinces, in the Ontario health-care structure hospital administrators have the responsibility for strategic planning within their organizations (Lomas, 1997). Hospital boards of directors partake in the strategic management of Ontario hospitals, but not in the strategic planning process (OHA, n.d.).

The focus group sessions in the qualitative phase took place outside of northwestern Ontario so that professional relationships with hospital administrators in that region did not introduce bias into the study. In the quantitative portion of the study, the selection of participants occurred through a list of hospitals provided by the OHA (OHA, 2007b). The list provided by the OHA designated hospitals into specific categories that the study employed to provide generalization to research results. The designation of hospital type by OHA might have reflected certain components of the hospital category and missed other important clinical categories that changed the level of the hospital.

Organizational performance measures used in the quantitative phase of the study included fiscal and clinical criteria created by the MOHLTC. All hospitals must respond to ministry-determined performance measurements, which provided a consistency to achieve reliable results. It was uncertain how many hospitals gathered any information on performance measurements outside of government-mandated indicators.

Summary

The focus of the sequential, mixed-method exploratory study was to (a) understand whether acute-care hospital administrators use strategic planning and (b) determine the relationships, if any, between strategy, hospital type, and organizational performance at the acute-care hospital level. As an expectation within the Ontario government was that hospital leaders would meet certain efficiencies and best practice standards, knowing whether hospital administrators used appropriate tools to meet strategically predetermined targets was important.

Introduced in this chapter were the study problem and a review of the acute health-care environment in the province of Ontario. The conceptualized model of known strategic planning components available for senior administrators appeared in Figure 1. The model represented an attempt to demonstrate how strategic planning components and the theoretical foundations of resource dependency (Pfeffer & Salancik, 2003) and resource allocation (Noda & Bower, 1996) could result in realized, emergent, or imposed strategy (Mintzberg & Waters, 1985). The research questions and hypotheses introduced in chapter 1 queried how hospital type, turbulence, or complexity of the environment and how the regulatory requirements contributed to strategic planning if strategic planning was done at all.

Chapter 2 contains a discussion of the historical perspective of the health-care setting in Canada and specifically in the province of Ontario. The literature was rich in perspectives on health-care strategic planning, but previous research was not necessarily appropriate for the Ontario health-care environment. Examined in the next chapter are the various theoretical foundations for strategic planning that future models can build off when considering different environments.

CHAPTER 2: REVIEW OF THE LITERATURE

The exploratory study mixed-method study had two purposes. The first purpose was to understand whether acute-care hospital administrators in Ontario use strategic planning, and if so, how the administrators used it or if specific strategic planning frameworks were used by hospital leaders of specific hospital types. The second purpose of the study was to determine the relationships, if any, between strategy, hospital type, and organizational performance at the acute-care hospital level. Chapter 1 included an overview of the rationale of conducting the research. The discussion in chapter 2 includes a detailed background of the Ontario health-care context and the theoretical foundation that drove the research questions and hypotheses. Also included in chapter 2 is a discussion of the historical overview of the Canadian health-care system, strategy as a field of study, strategic planning principles associated with strategic planning and organizational performance, and classification of taxonomies.

The strategy literature varies in style, context, and approach. Strategy literature in health care, while reflecting similar principles found in other classical strategy writings, has its uniqueness in reflecting an industry that involves acts that save human lives. The purpose of the literature review was to examine strategic planning used in the Ontario acute-care hospital system, processes used, and the relationship of strategic planning to hospital performance. Key hospital reforms introduced by the government raised expectations that hospitals collaborated in providing health care on a regional basis (Hanlon, 2001a; Health Services Restructuring Commission [HSRC], 2000; Ministry of Health and Long-Term Care [MOHLTC], 2006a). Whether the strategies to collaborate exist within the present hospital planning structure remains unknown. Hospital

administrators in the planning and decision making processes might have considered other criteria such as resource allocation, availability, and clinical outcomes. The regulatory processes as determined by the Canada Health Act also restricted the ability of hospitals to generate revenues that could contribute to overall financial well-being and organizational performance.

Documentation

Included in chapter 1 was a model outlining potential strategy types that an Ontario acute-care institution could potentially realize (see Figure 1). Development of the model included a variety of strategy literature sources providing a range of alternative strategy outcomes dependent upon the method of strategic planning. The literature sources, listed in Table 1, reflect the different approaches that hospital executives could take if they utilize existing strategic theories as guidelines in strategic planning.

To understand the complexities of the Ontario health-care system, the literature review encapsulates a historical overview of the health-care system as found in Canada and particularly in Ontario, as well as the context of Ontario acute-care hospitals. The review includes two relevant strategic theories applicable to the environment: resource dependency and resource allocation. The review also includes an exploration of the concepts behind strategic planning and taxonomies of strategy, as well as the deliberation on hospital performance in the Ontario acute-care environment.

A wide variety of literature on strategic planning and approaches to planning was available. Research exists on strategic planning leadership to generate revenue cycles (Kodjababian & Petty, 2007) and on strategic planning in a competitive health system (Bachrodt & Smyth, 2004; Nauert, 2005; Stichler, 2003; Szabla, 2007; Williams,

Hammas, & Karahalis, 2007; Young, 2005). Several researchers had presented strategic planning data focused on specific clinical areas within acute-care institutions (Ginn, 2004; Goding, 2005; Spallinga, 2004; Torgovicky et al., 2005). All of these authors (Kodjababian & Petty; Bachrodt & Smyth; Nauert; Stichler; Szabla; Williams, Hammas, & Karahalis; Young) had discussed strategic planning for organizations in a competitive or quasi-competitive framework and not a single-payer system, within specific acute-care departments, or a hospital as a whole.

Table 1

Categorizing Strategy Type Outcomes From Literature

Citation	Realized	Emergent	Imposed
Luke and Begun (1997)			Institutional barriers
Cueille (2006)		Environmental influences	
Porter (1996)	Positional		
Mintzberg and Waters (1985)	Planned	Flexible and responsive	Environment dictates patterns
Longest (2003)		Public policy development	Policy manifestation
Pfeffer and Salanick (2003)			External constraints
Bower and Gilbert (2003)			Internal constraints
Mintzberg, Ahlstrand & Lampel (1998)	Identified	Adaptive	

Wilcox et al. (2007) examined strategic planning in countries that provided universal care, although the focus of the research was how governments had identified specific additional funding arrangements to hospitals to reach predetermined targets on

wait-time strategies. The research did not include an examination into how hospital executives had performed strategic planning or had worked within set budget amounts to determine patient-care delivery. The review of literature revealed three articles in which researchers targeted a component of strategic planning in Ontario acute-care hospitals (Brown et al., 2005, 2006; Martin, Shulman, Santiago-Sorrell, & Singer, 2003), but not strategic planning in its entirety.

Because the literature lacked research that included a discussion on strategic planning within a single-payer system, accessing a wide variety of sources was necessary to develop a comprehensive understanding of strategic planning in the Ontario acute-care setting (see Table 2). Extensive use of government Web sites and documents from the MOHLTC and OHA was necessary to understand how government policy influences acute-care hospitals at a strategic level. The methodical review for pertinent information included various databases available through the University of Phoenix Library.

Although strategic planning in health care is a common phenomenon throughout the Westernized world, each country has unique care delivery methods. The literature review entertained strategic planning research for theoretical concepts from various countries, yet the ability to have relevant documentation on Ontario hospital strategic planning and health-care delivery was dependent upon government reports and independent organizations such as the Ontario Hospital Association (OHA). Literature that pertained specifically to Ontario health care since 2003 outside of government reports was difficult to obtain.

Historical Overview of the Health-Care System

A review of the health-care system in Canada required two lenses: one from the federal government perspective and one from the provincial government perspective. In Canada, a definitive division exists in government powers of responsibility in providing health care. The division has resulted in no standardized approach to providing health care across the country (Detsky & Naylor, 2003). The overview of health care includes a discussion on how the Medicare system came into existence and the specific delivery of health care in the province of Ontario.

Table 2

Overview of Literature Sources

Reference type	Literature captured
Government	Ministry of Health and Long-term Care, Joint Policy and Planning Committee, Romanow Report Papers, Local Health Integrated Networks, Health Services Restructuring Committee, Statistics Canada
Periodicals	EBSCOhost, ProQuest, ThompsonGale, MEDLINE database; periodical subscriptions; interlibrary loan articles
Independent organizations	Ontario Hospital Association, Canadian Council on Health Services Accreditation, Canadian Institute for Health Information, Conference Board of Canada
Reference books	Personal collection of doctoral learner, libraries

Overview of Health Care in Canada

The British North America Act became the constitutional document of the united territories of Canada in 1867 (Economist Intelligence Unit, 2002). The newly created provincial governments received certain responsibilities to ensure the safety and well-being of citizens. In 1867, religious institutions primarily provided hospital and health care delivery (Braen, 2004; Leeson, 2004). The provincial governments had the ability to declare quarantines and monitor asylums (Leeson). The federal government had the responsibility for marine or military hospitals (Braen; Leeson).

After World War II, specifically after the devastation of the Great Depression, the federal government made overtures to the provinces to create a national hospital insurance system (Leeson, 2004; Maioni, 2004; Taylor, 1987). The provinces did not readily accept the initial overture suggested in 1945 (Taylor, 1987). Talk concerning national health-care insurance disappeared from provincial–federal discussions for many years (Leeson, 2004). Meanwhile, provinces were committed to providing health insurance services. Optimistic that the federal government would be forthcoming with funding, in 1947 the premier of Saskatchewan, Tommy C. Douglas, began the first compulsory hospital insurance plan in North America (Taylor, 1973).

In the late 1950s, discussions arose again concerning the creation of a national insurance program. Some researchers contended that the federal government played a catalyst role for the development of nationwide provincial health plans (Braen, 2004; Maioni, 2004). Taylor (1987), who served as an advisor to the Ontario premier of the time, Leslie Frost, provided a different view. Taylor (1987) recalled that under the

leadership of Premier Frost, coercion of the federal government resulted in revitalizing the original 1945 insurance plan.

In 1957, the Canadian Parliament passed the Hospital Insurance and Diagnostics Act, which covered the costs of patient hospital admissions (Canada House of Commons Hospital and Diagnostic Services Act, Bill 165, 1957). By 1961, all provincial governments had their own health insurance programs to meet the federal standards (Maioni, 2004). The members of the government of Saskatchewan, still under the leadership of Douglas, continued to be a maverick in health-care politics by forcing the Saskatchewan Medical Association to accept government-determined fee-for-service payments (Taylor, 1973).

In 1966, the Canadian Parliament passed the Medical Care Insurance Act (Canada House of Commons Medical Care Insurance Act, Bill C277, 1966), which brought all physician fees under provincially run scheduled fee service. In 1984, the Canada Health Act merged the legislations from 1957 and 1966 into a comprehensive document, requiring provincial governments to meet certain standards to be eligible for federal funding transfers: public administration, comprehensiveness, universality, portability, and accessibility (Braen, 2004; Maioni, 2004). While Saskatchewan characterizes the birthplace of Medicare in Canada, without the cooperation of all provincial legislatures to mold the health-care plans to the federally enacted laws, the provision of health care across the country would be uneven at best. Despite regionalism and often-cantankerous relationships between the provincial and federal governments, health-care provision is one element that Canadians hold close to the collective psyche (POLLARA, 2003).

The federal government requires norms across the country for funding eligibility; still the concept of a Canadian health-care system does not exist (Maioni, 2004).

Provincial and territorial statutes determine health care (Taylor, 1987). Consequently, an application of a commonly held view of national health-care strategy also does not exist. Each provincial government coordinates health-care delivery in a slightly different way. Methodologies continue to change as the concept of what health care encompasses also changes (Leeson, 2004).

Variations of a theme have taken hold in nine of the 10 provinces (Lomas, 1997). Devolving authority to regional health-care groups was the direction that every province except Ontario has moved toward since the mid-1980s (Lomas, Veenstra, & Woods, 1997a). As health-care costs have increased, provincial governments began search for new governance structures to contain costs and increase efficiencies in the service delivery (Lomas, Woods, et al., 1997). Little research shows whether devolvement actually resulted in improved efficiencies through horizontal and vertical integration in providing community services (Lomas, Woods, et al.; Maioni, 2004; Sinclair et al., 2005).

Overview of Health Care in Ontario

Ontario hospitals, while called public, are actually registered charitable corporations responsible to a volunteer board of directors (Hanlon, 2001a; Sinclair et al., 2005). The hospitals are not-for-profit, are for the public, and follow the requirements of the Canada Health Act. Canadian hospitals are universally open to all regardless of nationality or proof of valid insurance. The hospitals receive the bulk of funding from the provincial government (Taylor, 1987).

The system of governance Ontario hospitals use created a strong community pressure on politicians to maintain the independent status of the hospitals. The historical evolution of the boards, prior to the national insurance program, served two functions: to ensure that needs of local patients are met and to develop strong ties between the hospital and the community (Sinclair et al., 2005). Boards tend to be parochial and are unable to entertain interhospital relationships stemming from a concern that the autonomy of the hospital would be compromised (Sinclair et al.).

The rapidly expanding budget required to maintain health-care standards motivated the Ontario government to implement hospital reforms seeking cost containment and efficiencies in health-care delivery. Sinclair et al. (2005) noted that in 2003, health-care expenditures consumed 10% of the gross domestic product of Canada (p. 37). Forecasts for 2020 showed health care will consume 50% of provincial expenditures (McIntyre, O'Sullivan, & Frank, 2003, p. 23). In Ontario during the fiscal periods of 1997-1998 to 2002-2003, health-care spending increased by 42% while provincial revenues increased by 31% (Sinclair et al., p. 38).

In 1996, the Ontario Parliament under the leadership of Premier Michael Harris amended the Independent Health Facilities Act (Ontario Legislative Assembly Independent Health Facilities Act, R.S.O., 1990) and passed the Savings and Restructuring Act (Ontario Legislative Assembly Saving and Restructuring Act, Part IV, Schedule F, 1996), which not only amended several health services, but also created the HSRC (HSRC, 2000). Designed to operate at arm's length from the MOHLTC, the commissioners were to facilitate hospital restructuring to maximize efficiencies (HSRC). The commissioners preferred that hospitals adopt an integrated delivery system;

nevertheless, the self-governing boards proved a formidable barrier to implementing system changes (Hanlon, 2001a). A great deal of uncertainty existed regarding what the new rules were and what expectations resulted from the restructuring that hospitals were to meet (Hanlon, 2001a). Commissioners commented on the relationship between the hospitals and the ministry and made suggestions on developing measurable outcomes (Sinclair et al., 2005).

In 2002, the Ontario government announced it was changing from a single-year funding formula to a multiyear plan for hospitals (MOHLTC, 2002). The OHA governing board believed that having a multiyear plan would allow hospitals to plan more efficiently (OHA, 2006). No researchers had studied the decision making process of hospital administrators in using either the single-year or the multiyear funding formulas. It was uncertain whether the multiyear formula would improve efficiencies.

While Ontario had been the lone provincial holdout in creating regional governance boards, this format changed. In March 2006, the Ontario Parliament introduced legislation to create Local Health Integrated Networks (LHINs) as the first step in creating regional monitoring of health expenditures (Ontario Legislative Assembly Local Health System Integration Act, Bill 36, 2006). The mandate of each regional LHIN organization was to plan, integrate, and fund health services in designated regions of the province (MOHLTC, 2006c). The movement toward the LHINs continued the recommendation of the HSRC members to consolidate the planning of health care at an interhospital level. It was uncertain if the provincial government felt that taking this step was necessary, as the present hospital governance structure did not support developing this approach on their own.

The responsibility of the LHIN board of directors is to create regional manifestos, called integrated health services plans that outline the strategic priorities that each regional LHIN had identified for the health-care sector (MOHLTC, 2007c). Funding for the majority of public health units in Ontario, including the acute-care hospitals, comes through the regional LHIN. An expectation is that the funded bodies would gravitate to activities that support the strategy, the measurements determined by the regional LHIN's integrated plan, and the MOHLTC (Ontario Legislative Assembly Local Health System Integration Act, Bill 36, 2006). The LHIN accountability structure requires that hospitals meet specific clinical and financial targets set on a yearly basis (MOHLTC, 2007b; OHA, 2005).

Concepts of Strategy in the Canadian Health-Care System

The field of strategic management has been active in the management literature since the 1960s (Ginter & Duncan, 2000; Mintzberg, 1994); the use of strategy became evident in the health-care language in the 1970s as costs increased exponentially and massive change occurred in funding methodologies (Luke & Begun, 1988). Strategic management encompasses multiple tasks on the part of the manager from the formulation of strategy through implementation (Luke & Begun, 1997). Strategic management research envelops both the prescriptive and the descriptive, yet a delineation exists between strategy process (formulation) and strategy content (competitive strategies; Ginter & Duncan, 2000; Mintzberg, 1994; Mintzberg, Alhstrand, & Lampel, 1998).

In the competitive environment, strategy involves obtaining an advantage over industry rivals. Porter (1996) believed strategy was about being different and using decision making as a means to create unique value. Mintzberg (1978) believed that

traditionally, strategy was a constructed plan explicitly designed for anticipated actions within a set environment. Due to the for-profit environment that exists within the United States, the topics of much of the health-care literature involve promoting strategy as a means of creating competitive advantage (Ginter & Duncan, 2000; Luke & Begun, 1988, 1997; Luke & Walston, 2006). The Canadian, and more specifically the Ontario hospital system, exist in a single-funder, not-for-profit environment (Canada House of Commons, The Canada Health Act, 1984). Government control over the health-care process determines hospital location and what services the hospitals will have (Ontario Legislative Assembly Health Care Services Act, Bill 94, 1985). Elimination of direct competition between hospitals for patients took place in the late 1990s through the latest hospital restructuring process (HSRC, 2000). At that time, identified hospitals with underutilized bed capacity within close proximity to another hospital closed or merged to create a cost savings (HSRC, 2000).

Approaching strategy within the Ontario hospital context is different from the normal lens of competitive advantage. Strategies in the Ontario context relate directly to the public policy and regulatory environment as conceptualized at Ontario Parliament or the federal government level (Wilson, 2004). The Ontario system differs from the other nine provinces in that each individual hospital maintains independent governing boards. As such, it is uncertain whether strategy formulation is a two-pronged approach in which the health-care minders in the Ministry of Health conceptualize strategy and the health-care providers at the individual hospital board and administrative level determine strategy.

Hospital administrators have power to some level regarding how to allocate the global funding budget the hospital receives through the independent hospital boards (OHA, n.d.). Other provinces had regionalized health boards that predetermined the budget expenditures of hospitals in their area (Lomas, Woods, et al., 1997). How the government anticipated a particular hospital might deliver health care might differ from the priorities seen by the independent hospital board (McKillop, 2004). Differences between the two levels regarding the concepts and idea of strategies could account for discrepancies between expected organizational performance and actual outcomes (Denis, 2004; Glouberman & Mintzberg, 2001a; OHA, 2004a). The differences increased confusion in the perception of hospital legitimacy within both the larger public-political sphere and the community (Ruef & Scott, 1998).

Health care differs from other industries in that the degree of interrelationships and the complexity of relationships create unique challenges in the development of strategy (Ginter & Duncan, 2000; Shortell & Kaluzny, 1997). The hospital environment, both task environment and macroenvironment, provides direction in how to meet identified challenges (Longest, 2003); yet the revolving and evolving relationships with professionals associated with the hospital complicate the understanding of the external environment. Of question was whether hospital administrators' strategic behaviors were categorical based upon the environmental conditions faced by the organization (Cueille, 2006). Shortell and Kaluzny identified several features in health-care organizations that make significant differences to the conceptualization of strategic management. Shortell and Kaluzny's features included the following:

1. Defining and measuring output are more difficult;

2. The work involved is more highly variable and complex;
3. More of the work is of an emergency and non-deferrable nature;
4. The work permits little tolerance for ambiguity or error;
5. The work activities are highly interdependent, requiring a high degree of coordination among diverse professional groups;
6. The work involves an extremely high degree of specialization;
7. Organizational participants are highly professionalized, and their primary loyalty belongs to the profession rather than to the organization;
8. Little effective organizational or managerial control exists over the group most responsible for generating work and expenditures: physicians; and
9. Dual lines of authority exist in many health care organizations, particularly hospitals, which create problems of coordination and accountability and confusion of roles. (p. 12)

Despite the recognized differences between health care and other industries, hospital administrators face multiple different theories on strategy development and ideas on how to create efficiencies and improve performance outcomes (Begun et al., 2003; Freed, 2005; Scott, 2003). Usually, the new strategic management theories produce confusion but little recognizable effective change in organizational efficiencies (Denis, 2004; Glouberman & Mintzberg, 2001a). Outcomes of the strategic process include hospital boards developing strategic initiatives based on their own self-interests regardless of the funding body's strategic goals (McKillop, 2004).

In determining strategy, Ontario hospitals must have management control systems designed to implement specific goals. Yet, consistently introduced are new restructuring

modalities to drive cost containment and organizational efficiencies. Due to the top-down funding approach of the government-payer system, the question arises as to whether hospital leaders had the knowledge of expectations in specific performance measures (Hanlon, 2001a; McKillop, 2004). If hospital administrators know the performance expectations of specific goals, there should be an examination of whether the skill or expertise needed to implement change is within the hospital administrator's competencies. Complicating the ability of senior management teams to meet the various new restructuring modalities is that planning is a retrospective activity (Mintzberg & McHugh, 1985; Mintzberg & Waters, 1985; Pfeffer & Salancik, 2003); organizations reverted to using or copying previously successful models based on precedents instead of future unknowns.

The policy directives from the MOHLTC determine expectations of each individual hospital. As relationships between hospital administrators and MOHLTC staff affect directly and indirectly the management of the hospitals, it is necessary to understand first strategic planning to determine how organizational performance expectations are woven into the fabric of hospital strategic management. Leontiades (1983) noted that three decisions conceptualized strategic management theory: mission, strategy, and plans. In the Ontario hospital system, three components of the decision making methods determine the strategy process (Hanlon, 2001a). The first component is that the relationship between the hospital and the government ministry included prior and recent sociopolitical environments. The second component was the association between the hospital administration and the professionals. The staff and other health-care providers created vulnerabilities as well as opportunities in strategy success. The third

component was the sociopolitical involvement of the hospital in relation to the community or communities the hospital serves. In chapter 1, a model introduced the potential relationships of these associations and involvements on realized strategy within the Ontario health-care system (Figure 1). The literature review involved an examination of strategic planning concepts due to the movement of resources within the acute-care environment.

Strategic Planning

A strategy is “a central, integrated, externally oriented concept of how the business will achieve its objectives” (Hambrick & Fredrickson, 2005, p. 52). Strategic planning has multiple roles: promoting responses organization wide to environmental change, creating methods to promote unit and organizational synergies, and developing devices to recognize and manage environmental uncertainty (Begun & Kaissi, 2005; Gee, 2007; Jennings & Disney, 2006). Achieving a strategy requires organizing resources and competencies as a response to environmental stimuli in some form of plan. Mintzberg (1994) described strategic planning as a formalized decision making process resulting in the realization of a phenomenon. Mintzberg (1994) also warned of numerous fallacies about strategic planning contributing to unrealized goals, discussed further in this section. Fredrickson and Mitchell (1984) showed that despite providing exhaustive knowledge to organizational decision makers through environmental scanning, organizations existing in unstable environments consistently showed a negative relationship between comprehensiveness and organizational performance.

Strategic planning includes several principles. Depending on the author, three to five principles are evident in the planning process, such as organization, discovery,

visioning, analysis and strategy formation, and implementation (Kaleba, 2006); environmental assessment, organization direction, strategy formulation, and implementation planning (Zuckerman, 2003); and formulation (including environmental assessment, setting objectives, and selecting strategic alternatives), implementation, and control (Jennings & Disney, 2006). Three principles stand out: environmental assessment, strategy formation, and implementation in strategic planning. Whether hospital executives in Ontario actually capture the three principles is uncertain. Researchers had noted leaders in other industries struggled to utilize all three strategic planning principles in the chosen strategy (Dye & Sibony, 2007; Raps, 2004). Dye and Sibony, as well as Raps, noted from survey results that only 10 to 25% of businesses had both strategic and implementation plans. Less than half of participants responding in both studies used methods to track and measure strategic initiatives in their organizations (Dye & Sibony; Raps).

While other components contribute to strategic planning such as mission, vision, and values, best practices and theoretical models, and regulatory requirements, the focus of the literature review was on examining environmental assessment, formation, and implementation of strategy. Mission, vision, values, and regulatory requirements potentially fit as part of the strategy formation. It was uncertain whether best practices or specific theoretical applications were used; this was one of the questions of the study. Therefore, a more detailed examination of environment, strategy formulation, and implementation was necessary.

Environmental Assessment

Several researchers have described environmental scanning and the importance of environmental scanning to the strategy process (Bourgeois, 1980; Hambrick, 1982; Miles & Snow, 2003; Yungger, 2005). Hambrick (1982) noted environmental scanning was an important step when considering an organization's ability to adapt. Miles and Snow used environmental scanning activities of executives as a framework for their strategic typologies. Bourgeois outlined a hierarchical relationship between environment scans and strategy. Organizational leaders perform environmental scanning to understand complex issues and to assist the organization in developing a strategic position addressing uncontrollable external influences (Albright, 2004). While environmental scanning assists administrators in identifying problem areas and opportunities for organizational effectiveness, environmental scanning behaviors and usage differ between organizations (Costa, 1995).

Environmental scanning includes two areas: internal and external. Internal scanning involves examining those "physical and social factors within the boundaries of the organization" (Duncan, 1972, p. 314), whereas external scanning involves gathering information about those "physical and social factors outside the boundaries of the organization" (Duncan, p. 314). Internal scanning includes the relationships of organizational members with each other (culture), and external scanning gathers intelligence on other groups, institutions, and individuals that have direct and indirect effects on the organization. Duncan contended that environmental scanning too often extended only as far as the external environment because the forces related to goal accomplishment.

Interpretations of the information and perceptions of environmental uncertainty are critical after collecting environmental information. Several researchers have discussed how managerial teams interpret the same groups of data differently (Begun & Kaissi, 2004; Bourgeois, 1985; Kumar & Strandholm, 2002; Snow, 1976). The variation in interpretation leads to questions regarding how different strategies formulate from the resulting analysis as well as whether organizational performance outcomes vary based upon the strategic initiatives designed to address the environmental factors. These are important questions, as some researchers believe administrators in a stable environment require less organizational strategic planning than administrators in uncertain environments require (Jennings & Disney, 2006). An assumption also exists that health-care professionals will adapt their organizations to meet external forces to improve organizational efficiencies and performance (D. A. Barr, 1998; Boyne & Gould-Williams, 2003; Layman & Bamberg, 2005).

Although gathering significant information on internal and external environmental forces upon the organization is important, the actual interpretation of the information and the perceived reality of the interpreters affect the formulation of the strategy itself.

Duncan (1972) outlined three areas of uncertainty administrators developed from the environmental scanning pertinent to the strategic planning process:

1. The lack of information regarding the environmental factors associated with a given decision making situation,
2. Not knowing the outcome of a specific decision in terms of how much the organization would lose if the decision were incorrect, and

3. Inability to assign probabilities with any degree of confidence with regard to how environmental factors are going to affect the success or failure of the decision unit in performing its function. (p. 318)

The primary purpose of environmental scanning is to make forecasts of future conditions the organization will encounter (Mintzberg, 1994). The certainty or uncertainty that administrators take with them from the scanning process relies upon the method of scanning performed, the frequency of the scanning activity, and cognitive biases about the collected scanning information (Hambrick, 1982). Environmental scanning also promotes boundary-scanning behaviors to protect the organization from uncertain external forces or promotes internal structural changes creating buffers (Fennell & Alexander, 1987).

Strategy Formation

Mintzberg et al. (1998) described an analogy of strategy formation as involving blind men and an elephant: the part of a strategy in one's grasp determined the vision of what strategy was. The resulting vision becomes the reality upon which strategic planning forms. Mintzberg et al. identified 10 schools of strategic formation categorized into three groups: the design, planning, and positioning schools (prescriptive: how strategy should be formed); the entrepreneurial, cognitive, learning, power, cultural, and environmental schools (descriptive: how strategies are made); and the configuration school (transformative: how does strategic change happen). The prescriptive viewpoint enforces the perspective of strategy as a plan whereas the descriptive stance involves looking at strategy as patterns created through past behavior, and the transformative strategy takes the organization into the unknown (Mintzberg et al.).

All of the different strategy schools result in a realized strategy; what is questionable is how the strategy emerged. Strategic intentions that came to fruition are deliberate strategies. Other strategies are not intended, but through actions taken over time, they merged into a consistency or pattern classified as an emergent strategy (Mintzberg, 1978, 1994; Mintzberg et al., 1998; Mintzberg & McHugh, 1985; Mintzberg & Waters, 1985). In the case of Canadian health care, government and professional bodies' requirements and regulations control much of the behaviors of acute-care hospitals. In the Ontario acute-care setting where LHIN administrators require specific hospital accountability factors and the provincial government may use hospitals to carry out their own strategies to further health-care political agendas, as a certain amount of imposed strategy might exist (Boyne & Gould-Williams, 2003; Burger-Helmchen, 2007; Byington et al., 2007; Majone, 1974, 1975; Mintzberg & Waters).

Strategy formation revolves around the relationship of three specific components: the environment that changes on an infrequent basis, with variations in the degree of change; the organizational design, constructed to seek stability regardless of environmental characteristics and uncertainty; and organizational leadership, whose function is to balance the environmental change and organizational structure (Mintzberg, 1978). More recent strategic formation research included stakeholders and the importance of the stakeholder to organizational stability (Daake & Anthony, 2000; Fajans, Simmons, & Ghiron, 2006; Hansen, Bode, & Moosmayer, 2004; Lim et al., 2005). Other researchers noted that strategic formulation capability is dynamic in that the strategy formulation must match strategic orientation or environment (Blumentritt & Danis, 2006; Slater, Olson, & Hult, 2006).

The environmental scanning process brings information to decision makers determining strategic activities to meet organizational goals. The process of scanning is a formal mechanism systematically searching for specific information. Environmental scanning might not provide the right information to administrators making strategic decisions. Daake, Dawley, and Anthony (2004) found that despite providing the strategic planning team with as much formal data as possible, the administrators were not satisfied with the quality of information provided and consistently requested additional information. Daake et al. discovered that cognitive limitation existed when administrators, provided with new information, relied more on informal data sources to substantiate the new information. While Daake et al.'s study group considered new data sources, administrators retained filtered information only if the new information supported existing beliefs and biases.

Strategic planning becomes a challenge when the cognitive biases of the decision makers determine responses to environmental stimuli. Barnes (1984) identified several cognitive deficiencies that affected the effectiveness of strategic planning. Frequency of events occurring incites administrators to easily recall situations and prepare for the event. The alternative is bias that decision makers have against examining other risk opportunities. Hindsight involves using past decisions and eventual outcomes to color cause-and-effect relationships. Barnes noted that environmental scanning and measurement phases were more susceptible to hindsight bias. Judgments made of correlational and causality relationships risk having bias when considering forecasting as absolute. Although a correlation might exist between variables, causation is not evident. Representativeness bias exists when decision makers consider an outcome to be

representative of the process from which it derives regardless of the reliability of the outcome (Barnes).

Cognitive limitations lead decision makers to simplify information processing even when making critical decisions (Barnes, 1984; Daake et al., 2004; Hodgkinson, Bown, Maule, Glaister, & Pearman, 1999; Hurtado, 2006a). One method to overcome the potential for cognitive limitations is to develop tools that require decision makers to enter into detailed, structured, and systematic thought processes prior to determining a course of action (Hodgkinson et al.). Burgelman (1988) called cognitive limitations a social learning process, where integration of managerial action and cognition of the process needed to shape strategy takes place.

Two sets of research on strategic priority setting have taken place in Ontario acute-care institutions. The research was limited to the development of strategic priorities within the strategic planning process. Neither of the research groups examined strategic planning as an activity. Martin et al. (2003) from the Center for Bioethics at the University of Toronto focused their efforts on individual hospital strategic planning. Martin et al.'s research was the first on priority setting within the strategic plan at the local hospital level in Ontario. The studies by this group of researchers were limited to academic and larger community hospitals located in southwestern and southeastern Ontario (J. Gibson, personal communication, November 29, 2007). Two hospitals, Sunnybrook in Toronto and The Ottawa Hospital in Ottawa, developed independent tools to facilitate discussion within the hospitals on how to determine criteria identifying priority goals within the strategic setting, using bioethics as a foundation. Not empirically

validated, the priority-setting tools are used internally to those hospital organizations (J. Gibson, personal communication, November 29, 2007).

Another group of University of Toronto researchers extended priority setting beyond the individual hospital's strategic plan and required hospital administrators to develop strategic priorities on a system level (Brown et al., 2005, 2006). The purpose of determining priorities on a provincial level was to compensate for the regulatory environment of Ontario acute-care institutions. By setting priorities on a system level, Brown et al. (2005, 2006) believed hospital administrators would think about how to compete with other hospitals for scarce resources. Although the government provides funding formulas on a 3-year basis, Brown et al. (2005, 2006) noted that without understanding what the shared priorities were on a system level, individual hospital strategies were short-term, inaccurate, and unable to be strategic for longer term goals.

Results of the second group of studies were both positive and negative. Although internal hospital strategies move toward perceived system strategies and a greater ability exists for hospitals to agree upon system strategies, a definite lack of resources is available to hospitals that impede the ability to implement a range of strategic decisions (Brown et al., 2006; Snyder, Wenger, & De Sousa Briggs, 2003). Another limitation was that the surveys only examined the strategic priorities of hospital CEOs (Brown et al., 2005). Although Brown et al. (2005) solicited other stakeholders in the strategic process and requested input to the development of the strategic priorities, cognitive biases were a limiting factor in the development of a system approach and might not capture important patient-perspective needs.

The limitation of CEO involvement in the development of strategic priority setting in Ontario acute-care hospitals is important to note because physicians and nurses provide the care delivery of patients, a primary stakeholder. As the hospitals strive toward efficiencies and cost effectiveness, the ability to identify methods to achieve these efficiencies falls upon the middle managers. Middle managers of the hospital are primarily in nurse management positions, with physician involvement as the chiefs of medical and surgical sections. The middle managers must work within the organizational culture to effect change and because the middle managers immerse themselves in the culture on a daily basis, middle management becomes an effective communication tool between senior administration and employees (Embertson, 2006).

If the amount of differentiation between functional units signifies organizational complexity (Dooley, 2002), hospitals fall within this definition as there are by necessity not only a large diversity of professional specialties, but also different authority structures, technological applications, and practices based upon physician preference. The integration of the various balances within this environment is difficult, if not impossible, for senior managers to manipulate without the direct involvement of middle managers (G. R. Baker, 2001). Without the middle managers' direct involvement with organizational change, organizational culture will suffer, threatening the ability to meet performance expectations (Freed, 2005; Friedman & Goes, 2001; Poulin, Mills, & Spiller, 1998).

Although the contributions of middle managers to the strategic formation process is recognized, the group's involvement in the strategic process has been limited to providing information to the senior management team (Batalden, 2001; Burgelman, 1983; Carney, 2004, 2006; Jennings & Disney, 2006; Pappas, Flaherty, & Wooldridge, 2004;

Prybil, 2007; Succi & Alexander, 1999). Researchers have not shown that physician involvement improves hospital efficiencies (Succi & Alexander; Schultz, Pal, & Swan, 2004), although non-clinician administrators' lack of knowledge about patient-care delivery does affect the ability to gain strategic insights of the internal environment.

The strategic changes necessary for acute-care hospitals frequently take place at the micro or internal level (G. R. Baker, 2001). For changes to take place, clinicians must assist in developing best practices that link individual practices to larger organizational goals (Greenia, 2004). Without creating these linkages, physicians and middle managers continue to act in self-serving ways that do not move the organization toward improvements in organizational performance (Carney, 2004).

Strategy Implementation

Organizational leaders spend a great deal of time focusing on forming strategy, although Raps (2004) described implementation of the strategy as a “strategic afterthought” (p. 53). Implementation of many well-thought-out strategies never occurs (Mintzberg, 1994), possibly because the implementers have not considered individual and group resistance or apathy at the organizational level (Lines, 2007). Implementers might fail as a result of being unclear about the conceptual processes or elements necessary for strategic implementation (Pryor, Anderson, Toombs, & Humphreys, 2007).

Bourgeois and Brodwin (1984) captured five process approaches for strategic implementation, with each process building upon the preceding one with increasing levels of sophistication and participation by organizational members. As each level of strategic implementation unfolds, ingrained into the process are four principles of successful implementation: culture, organization, human resources, and control systems

or measurements (Rap, 2004). Still, although principles exist for successful strategic implementation, a broad conceptual model is lacking (Aaltonen & Ikavalko, 2002; Pryor et al., 2007).

In the health-care environment, because a knowledge disparity exists between clinicians and non-clinician managers, the ability to be successful in this activity diminishes without an integrated approach to strategic implementation through an organizational learning plan (Kenny, 2006). Beer and Eisenstat (2000) listed six barriers to successful strategic implementation: top-down or laissez-faire senior management style, unclear strategy and conflicting priorities, ineffective senior management team, poor vertical communication, poor coordination across functions, and inadequate down-the-line leadership skills and development. Without the involvement of physicians and nurse managers, senior management teams might have difficulty interpreting the strategic plan into a communication structure that integrates with overall patient-care systems.

The position of strategy implementers is important to consider. Bourgeois and Brodwin (1984) believed that using individuals with formal power was detrimental to the implementation process. Because an association exists between strategic planning and senior managers or upper echelons (Cannella & Monroe, 1997; Davies & Davies, 2004; Hagen, Hassan, & Amin, 1998; Hambrick & Mason, 1984; Hughes & Beatty, 2005; Ireland & Hitt, 1999/2005), using only those in positional power as change agents might be ineffective to the strategic implementation process. Instead, the implementation process needs to draw upon middle managers to fulfill much of the change agent role.

Brauer and Schmidt (2006) indicated organizations that function in uncertain environments had a difficult time maintaining a strategic implementation process and

were constantly realigning the strategy due to external influences. Brauer and Schmidt noted that the results indicated that the high levels of environmental ambiguity cause some organizational leaders to “prematurely react to perceived changes in their external environments” (p. 217). If organizational leaders have not developed prior processes to monitor the implementation, it is difficult to evaluate the environmental changes and the influence of the changes upon the strategy (Pryor et al., 2007).

Challenges of Strategic Planning

Having a strategic plan is not the same as strategic planning (Mintzberg, 1994). The process of strategic planning has multiple variables that result in each organization creating a unique strategic vision. Strategic planning usually has an association with environmental change, and often these changes have never occurred before (Hagel, 1994; Mintzberg, 1994). Thus, predetermining and forecasting is not accurate especially on a long-term basis; strategic planning is dynamic and unpredictable. Implementation of organizational strategy does not follow a predetermined plan or proceed without interruption.

The role of environmental scanning on the accuracy of strategic planning is unclear (Boyne & Gould-Williams, 2003; Brews & Hunt, 1999). Too much information does not assist strategic decision makers to determine strategic actions. Cognitive biases and lack of intelligence on organizational strengths and weaknesses weaken the ability of strategic planners to analyze organizational competencies or a lack of organizational competencies (Mintzberg, 1994). The tacit knowledge that strategic planners have gathered through experience will be a greater factor in strategic planning than a wealth of new environmental information.

Organizational culture and design plays a considerable role in the planning and implementation of strategy. Several subcultures might exist within an organization, each requiring a modified approach to the overall organizational strategy (Hagel, 1994). Organizational design and learning concepts of the different subcultures add complexity to the implementation of strategy on a functional level (Brews & Hunt, 1999). Trivializations of the importance of middle managers, and the middle managers' acceptance or rejection of the strategic plan are dangerous to the overall strategic process. If managers disassociate themselves from the strategic planning, there will be little interest in the actual implementation of the plan (Mintzberg, 1994).

Strategy Classification

Classification in the scientific sense serves the purpose of organizing phenomena into categories that then acquiesce to further scrutiny (Morris & Pitt, 1993). Classification provides a foundation for explanation, prediction, and using similarities in the phenomenon; permits the development of principles; identifies conditions where the principles are valid; and generates generic constructs to understand complex sets of variables (McKelvey, 1975). Classifications divide into two definitions: conceptually derived schemes are typologies and empirically derived schemes are taxonomies (Hambrick, 1984; McKelvey). The taxonomy includes the classification system, the theory from which the classification system derives, and methods used to construct the taxonomy (Chrisman, Hofer, & Boulton, 1988).

According to Chrisman et al. (1988), a classification system had the following four objectives:

1. Differentiation,

2. Generalization,
3. Identification, and
4. Information retrieval. (p. 415)

A strategy classification system brings consistency when examining variables. Determining what variables to classify within the strategic context is daunting and might require a multilevel taxonomy in order to accommodate uncontrollable variables and strategic choices (Hambrick, 1984). Because a lack of common reference points are available for classifying business strategy, established theories in the strategy area studied provide the identifying features for variables in order to provide structure and applicability of a strategic taxonomy (Hambrick; Kald, Nilsson, & Rapp, 2000; McKelvey, 1975; White, 1986).

To meet the objectives of taxonomy, the taxonomic units or taxa within the classification system must be mutually exclusive, internally homogenous, collectively exhaustive, stable, and based on relevant language or names (Chrisman et al., 1988). A concern for the study was that the multivariate analysis would be free from the influence of other strategic planning taxonomies. Thus, the research component included the employment of guidelines recommended by McKelvey (1975) to determine if a classification system for Ontario acute-care hospitals would be possible.

Resource Theories

Acute-care hospitals in Ontario are largely dependent upon the provincial government to provide funding resources. Physicians and nurses also greatly influence the use and designation of resources attainable by the hospital. Examined for their

contributing factors to strategic planning within the Ontario acute-care environment are two resource-based theories: resource dependency and resource allocation.

Resource Dependency

The MOHLTC through the regional LHINs provides the majority of the funding required by acute-care institutions to maintain health-care services as well as grants legitimacy to the hospital as a health-care provider (MOHLTC, 2006b). A formal relationship between hospitals and the governing health organizations emphasized interdependency between the agents. The interdependency resulting from the distribution of legitimacy and resources from one agent to another contributed to the behavior and actions taken by the hospitals to achieve objectives as set out by the governing body (Contandriopoulos, Denis, Langley, & Valette, 2004). Other professional and accrediting bodies regulate activities within the hospital structure. The professional bodies maintain their own intricate connections and interdependencies with the MOHLTC (College of Physicians and Surgeons of Ontario, n.d.). Resource dependency theory supports the connectivity between multiple agencies in the Ontario acute-care setting that were unable to separate from the governing agency controlling resources (Zucker, 1987).

Pfeffer and Salancik's (2003) germinal work on resource dependency theory focused on how well the organization met the expectations of a group concerned about effectiveness. As organizational leaders direct actions to meet these external standards, three potential behaviors exist:

1. The organization alters its environment,
2. The organization changes and adapts its behaviors and actions to the forces placed by the external organization; and

3. The organization seeks to find additional methods to determine legitimacy within the environment, such as positional power. (Pfeffer & Salancik, p. 11)

In a resource dependent strategic plan, senior management teams used the movement of the hospital leaders to solidify the hospital's legitimacy within the community environment to manipulate the interorganizational linkages that existed between the resource dependent hospitals and the resource richer MOHLTC (OHA, 2007a). To maintain organizational viability and autonomy, the senior administration teams adapt the behavior of the hospital to meet organizational objectives as set by the LHINs and the ministry, while meeting community expectations on health-care provision (Goes & Park, 1997; Goes, Friedman, Seifert, & Buffa, 2000).

The MOHLTC holds an additional tool in the ability to regulate how acute-care institutions function based on perceived need within the community (MOHLTC, 2007b). Using regulatory devices, governments are able to coerce the movement of resources within the environment and determine how administrators made economic decisions (Banks et al., 1999; Christensen & Bower, 1996; Stigler, 1971). The regulatory power that the government maintains over institutions creates power structures beyond the realm of dependency upon the government to provide needed resources to operate (Ontario Legislative Assembly Health Care Services Act, Bill 94, 1985). The power structures created within the interfirm relationship heighten the tension between the administrators and the government funding bodies, potentially restricting the ability to make strategic decisions based on organizational need rather than satisfying political masters (Palmer, 1983).

Resource Allocation

Resource allocation has similarities to resource dependency theory, with multiple partners and multiple levels of influence in determining the use of scarce resources (Christensen & Bower, 1996). Although the focus of resource dependency is on the strength that external forces had upon the availability of resources, resource allocation concentrates on the influence of agents internal to the organization upon the planned use of resources (Bower & Gilbert, 2003). Noda and Bower (1996) purported that the knowledge power of middle managers or comparable groups within an organization is the critical factor in determining the allocation of scarce resources for greatest efficiency and effectiveness. The resource allocation model of internal resource determination uses interactions between corporate context and strategic behavior to solidify strategic choice (Burgelman, 1983; Child, 1972). Within the health-care setting, nurses and physicians have the greatest knowledge of resource use and allocation. The knowledge base directs an insight into which resources are necessary to provide standard-of-care treatment and the distribution of scarce resources throughout the health-care setting.

Bower and Gilbert (2003) described four components to the resource allocation model. First, strategy results from resource allocation decisions within the organization. Second, the groups of individuals with influence in the organization due to their knowledge base play a significant role in shaping strategy for the organization. Third, the structural context that determines the allocation of resources then shapes the strategy of the organization. Finally, decision making ensues in organizational uncertainty resulting from strategic consequences (Bower & Gilbert). If the decision making middle managers

(or physicians) have objectives separate from organizational goals, organizational inefficiencies result from a misappropriation of scarce resources.

The differentiation between physician-manager objectives and senior-manager organizational objectives magnified when introducing risk management into the equation. Ontario acute-care hospital senior administrators were accountable to government policy makers on hospital cost-efficiencies, but not within hospital-LHIN accountability reporting structures were medical-legal and patient-satisfaction scores (MOHLTC, 2007c). To physician and nursing practitioners, medical-legal and patient-satisfaction were highly considered when considering resources needed within the hospital environment and allocation of such resources (Bridges, 2004; Wild, 2005).

The rapidly increasing costs of health technologies contrasts strongly with the quickly depleting funding dollars to purchase, utilize, and maintain such technologies. Most hospitals in Ontario do not have any form of health technologies assessment panel. Without an objective review of newer technologies available on the market, physicians maintain greater power to allocate resource dollars into personal choice purchases outside of the organizational strategic direction or level of affordability (Coyle, Buxton, & O'Brien, 2003; Fenwick, O'Brien, & Briggs, 2004; Hivon, Lehoux, Denis, & Tailliez, 2005; Johri, & Lehoux, 2003; Lehoux, Denis, Tailliez, & Hivon, 2005; Lehoux, Tailliez, Denis, & Hivon, 2004).

The personal agendas driven by internal stakeholders create difficulties in maintaining a balance between planned and emergent strategies necessary for organizational adaptation (Mohanis et al., 2005; Bower & Gilbert, 2003). As patient-care needs change, so do allocation of resources and the strategic context of the organization

(Hemmasi et al., 1997; Noda & Bower, 1996). Both planned and emergent strategy processes compete for finite resources, and internally, organizational members trade resources between them. The internal shifting of resources outside of the organizational strategic plan compromises the organization's ability to absorb risk, contributing to uncertainty and complexity of the organizational environment (Bower & Gilbert; Bridges, 2004; Christensen & Bower, 1996).

Organizational Performance in Ontario Hospitals

As health-care budgets continue to increase, governments wish to ensure the utilization of allocated monies efficiently and effectively. The reason behind health-care reform in Ontario was the use of indicators identifying excess capacity at the hospital level and the improvement of hospital performance within a limited budget (Hanlon & Rosenberg, 1998; Hay Group, 2004; HSRC, 2000; MOHLTC, 2007b). What indicators, what performance levels, what efficiencies have some commentary (Joint Policy and Planning Committee [JPPC], 2006b; MOHLTC, 2006a) but were lacking in specifics directed toward specific hospital type.

In 2000, analysts at the World Health Organization issued a report dedicated to discussing the measurement of health-care efficiencies. The report identified five measurements necessary to monitor the effectiveness of health systems: "The overall level of health; the distribution of health in the population; the overall level of responsiveness; the distribution of responsiveness; and the distribution of financial contribution" (World Health Organization, p. 42). The measurements challenged health policy makers to create performance evaluations on resource allocation and on the achievement of population health objectives (Jacobs, Smith, & Street, 2006). The

Canadian Council of Health Services Accreditation (CCHSA; 2003) outlined eight health performance indicators: acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency, and safety. Although standardized indicators exist across Canada, each province has its own methods of accountability for government funding and the priorities of the indicators could vary by province and by hospital. Unless a consistency exists in understanding how to use metrics, hospital administrators might be gauging strategic performance so that it is impossible to compare peers (Krentz, DeBoer, & Preble, 2006; Pun & White, 2005).

The measurements of efficiency become even more challenging in the Ontario health-care system, which has a lack of market-driven strategies. The normal methodologies used to determine performance (revenues, operating margin) in for-profit organizations do not exist in a single-payer system. As hospitals in Ontario move toward a regionalized approach with the creation of the LHINs, monitoring will include meeting regional patient needs (MOHLTC, 2006c). Currently, all performance measures use a single institutional approach (Yap et al., 2005). How performance measurements evolve might depend upon the types of strategic processes the hospitals employ or create in this changing environment. Recent research reported that the system-balanced scorecard is complex and did not assist hospital administrators to determine strategic priorities (Parkinson, Tsasis, & Porporato, 2007).

Additional challenges exist for Ontario and Canadian hospitals in that data collection systems are rudimentary (Jacobs et al., 2006). Outdated technological equipment inhibits the ability of hospital and government officials from gathering relevant information and developing a relevant analysis (DeRosario, 1999; Millar, 2001).

Whether the Ontario provincial government examines performance efficiency and effectiveness as a system-wide approach or creates allowances for individual hospital-specific population needs when creating public policy is unknown. Jacobs et al. (2006) cautioned that while a whole system approach was desirable, identifying specific inputs as well as identifying the decision makers rendered the process impractical in application.

Health-care performance outcomes measure data on either efficiency or effectiveness in a facility (DeRosario, 1999). Indicators that measure efficiency examine the association between input costs and outcomes (inpatients versus outpatient procedures, ambulatory care costs; MOHLTC, 2007c). The indicators measuring effectiveness not only capture the cost analysis of inputs and outcomes, but also add quality of care into the formula (DeRosario). Due to multiple outputs such as organizational environment influences, the complexity of acute patient care, and the unreliability of data, obtaining accurate performance measurements in health care is multifarious (Jacobs et al., 2006).

Additional linkages exist that researchers contend affect the ability of the organization to meet performance measurements. The role of environment (Fredrickson & Mitchell, 1984; Harrington, Lemak, Reed, & Kendal, 2004; Mobley & Magnussen, 1998), strategic format (Miller & Cardinal, 1994; Mintzberg, 1994; Pearce, Freeman, & Robinson, 1987), community orientation (Ginn & Lee, 2006; Lonial & Raju, 2001) and interorganizational relationships (Goes & Park, 1997) add multidimensional complexities to understanding hospital performance. In the case of Ontario hospitals, the disparities between rural and urban academic hospitals, anticipated performance of hospitals by the provincial government, and expected developing relationships between hospitals (HSRC,

2000) require an understanding of the complexities and impact upon hospital performance.

In 1997, the members of the OHA and the provincial government collaborated in creating a comprehensive, system-wide measurement on hospital performance (Pink et al., 2001; Yap et al., 2005). The provincial government provided funding to the University of Toronto using an arms-length approach to the project capitalizing on the research application of the work and requested the research team to collect data, devise a measurement methodology, and report on the findings (Pink et al., 2001). The result was the *Hospital Report '98: A System-wide Review of Ontario's Hospitals* (G. R. Baker, Anderson et al., 1998). The performance methodology supported by the researchers was from Kaplan and Norton's *Balanced Scorecard* (2001). Health-care literature contains some support for the balanced scorecard as a performance methodology of merit (Chan, 2006; Chow et al., 1998; Inamdar & Kaplan, 2002; Voelker et al., 2001). Other researchers disagree that the scorecard is beneficial in evaluating health-care organizations (DeBusk & Crabtree, 2006; Wicks & St. Clair, 2007).

In 1999, a second report was issued: *Hospital Report '99: A Balanced Scorecard for Ontario Acute Care Hospitals* (G. R. Baker et al., 1999). This report as well as subsequent *Hospital Reports* use a variety of indicators to measure hospital performance on a system basis as well as create individual hospital scorecards (G. Baker et al., 1999). G. Baker et al. (1999) recognized, as earlier cautioned by Jacobs et al. (2006), that system-wide performance measurements were complex and to understand the intricacies of performance measurement comprehensively, individual hospital concepts of strategy,

environmental influences, and responses to the community were necessary (Yap et al., 2005).

In several reports, Ontario hospitals received recognition as having the best overall performance in Canada in meeting health outcomes, health-care utilization, and organizational performance (Hay Group, 2004; OHA, 2004b). The continuing pressure on acute-care hospitals to treat more patients with less funding, yet maintain critical health outcomes, will require senior administration teams to do some planning. The type, amount, and detail of planning might be dependent upon the hospital size, geographical location, and availability of resources. It was uncertain when setting performance measures as benchmarks whether the provincial government was cognizant of the variations within the acute-care setting or took into account priorities as set by individual hospital boards.

Context of the Ontario Acute-Care Hospital System

Ontario has 136 acute-care hospitals: 70 small hospitals, 13 teaching hospitals, and 53 community hospitals (MOHLTC, 2006b). All teaching hospitals and the majority of community hospitals are in southwestern and southeastern Ontario, capturing the bulk of the population of the province (MOHLTC, 2006b). Of the 70 small hospitals, 22 located in northwestern and northeastern Ontario are in rural areas (MOHLTC, 2006b). All hospitals in the province fall under a single-payer system where the Ontario provincial government, through the auspices of the MOHLTC, provides approximately 89% of the required revenues that acute-care hospitals require for continuing operations (Gruca & Nath, 2001, p. 92).

During the HSRC's tenure from 1996 to 2000, the number of acute-care hospitals in the province of Ontario decreased from 168 to 136 (HSRC, 2006). Through the use of special powers legislated by the province, the HSRC merged or closed a number of hospitals across the province in a bid to reduce the number of unoccupied beds, improve efficiencies, and consolidate hospital services for cost effectiveness (HSRC, 2000). Some multisite organizations, usually teaching hospitals, are in urban areas; the majority of the hospitals are single-site centers (MOHLTC, 2006B). Several small hospital organizations that are in close proximity to each other, while maintaining their own individual incorporations, share a leadership team. Although a few hospitals affiliate with religious organizations, the vast majority are nonprofit corporations with an independent board of directors responsible for the application of health care in their respective communities (Hanlon, 2001a).

A debate has been taking place in the health-care literature over the importance ownership plays in hospital efficiencies (C. M. Baker et al., 2000; Burgess & Wilson, 1996). Burgess and Wilson suggested nonprofit hospital organizations choose managers who have a greater interest in providing services to the community than generating profits. Burgess and Wilson also queried whether the lack of a profit-making environment leads to a decreased vigilance in reducing waste in the organization. The context of ownership in U.S. hospitals has proven to create differentiations in efficiency (C. M. Baker et al., 2000; Younis, 2004). The ability of some U.S. hospitals, due to the type of ownership, to choose which patients the hospital will accept or reject based upon insurance availability has an impact upon financial revenues and efficiencies (Gruca & Nath, 2001). Mobley and Bradford (1997) showed that the more competitive nonprofit

organizations became within the environment, the more that the nonprofit organizations adopted efficiency techniques practiced by for-profit hospital organizations.

The Ontario health-care environment does not participate in a competitive environment because the provincial government controls hospital budgets and spending and must approve all new patient services and large capital expenditures (Gruca & Nath, 2001; Ladak, 1998; OHA, 2004a). Thus, drivers for profit making do not exist; hospitals must provide medical care to patients regardless of ability to pay, type of provincial or out-of-country insurance policy, or the existence of medical insurance at all. Other organizational structural contexts must play a larger role in identifying characteristics of Ontario hospitals, categorizing them into comparable units.

Pugh, Hickson, Hinings, and Turner (1969) outlined specific areas of organizational context that had relevance to the functioning of an entity including history, ownership and control, charter, technology, location, and dependence. Kimberly's (1976) work contributed to Pugh et al.'s discussion on the context of size to determine organizational structure. Although hospital ownership has negligible effects on the performance of the organization in the Ontario hospital scenario (Gruca & Nath, 2001), control of decision making processes is a significant factor in academic teaching hospitals (Fried, Pink, Baker, & Deber, 1994). Other contexts might bring important considerations in developing public policies regulating hospital management and funding protocols. What differs in the examination of the literature from the Ontario health perspective is that other researchers have viewed organizational context as specific to individual firm performance, while in the Ontario health-care environment, the examination of context is a system-wide approach when creating funding policies.

Gruca and Nath (2001) found no differences in organizational efficiency in Ontario hospitals, despite size and location. Gruca and Nath based the research on 1986 data before major health-care structural reforms took place. More recently, Ontario government health-care policies have considered additional challenges in delivering health care based upon geography and hospital type (JPPC, 2005; Ministry of Health, 1998). Awareness by policy makers of organizational structure differences affects the development of funding formulas that govern hospital budgets.

In Ontario, multiple hospital funding methodologies have evolved, with the most significant changes taking place since the early 1990s (Ladak, 1998). In an overview of the Ontario health-care system, Ladak reported that when the Medicare system was first developed in 1958, hospitals requested funding through line-by-line reporting.

Governments found that the funding formula did not allow for yearly predictions and, to anticipate budget requirements for legislative approval, moved to a global funding system in 1969 (Ladak). Global funding used the previous year's funding amount and added an additional sum anticipating higher operational costs.

In the 1980s, the Business Oriented New Development (BOND) funding initiative was introduced (Ladak, 1998). The Ontario government hoped to encourage hospitals to operate in a more business-like manner through cost controls and increased non-government-sponsored revenues (Ladak). The established BOND method added a multicomponent formula to accommodate additional high-cost programs for hospitals operating beyond the small hospital base:

1. A base budget (or global budget) equaling the sum of the previous year's Ministry of Health allocation;

2. An inflation or economic adjustment;
3. A small hospital adjustment equaling one percent of their budget, given to hospitals with budgets less than \$3.5 million or less than 50 acute care beds;
4. New or expanded program funds to cover approved incremental operating costs of new services or programs;
5. Growth funding to account for population pressures;
6. Life-support funding for high cost, specialized services; and
7. One time extraordinary funding for specific projects or high cost drugs. (Ladak, p. 2)

In the late 1980s, introduction of resource intensity weights as part of the case-mix groups methodology assisted in determining funding costs to hospitals (Ladak, 1998). The new methodology produced large concerns from hospital managers, as there was no established data collection methodology in the province at that point. The government used data collected in the states of New York and Maryland to determine case-mix groups for the province of Ontario (Ladak). Well into the mid-1990s, the Ministry of Health used Maryland data to determine resource intensity weights for the Ontario case-mix groups while initiating data collection pilots involving a small number of hospitals (Ladak).

The restructuring process of the HSRC introduced a new funding formula: rate and volume equity funding methodology (Ladak, 1998; Ladak & Pink, 1997). Built into the rate and volume equity funding methodology are specific adjustments for hospital size, level of acuity, geographic location of the hospital, technology, patient

socioeconomic status, availability of community resources, and labor and physical plant costs (Ladak). The contextual factors then indicate allocation of predetermined funding amounts among hospitals (Ladak & Pink).

In the 2005-2006 fiscal year, the MOHLTC introduced a multiyear funding formula (OHA, 2006). The new funding formula calculates hospital base operations, expected population growth, and the efficiencies shown by the hospital to that point to determine funding levels for three years (JPPC, 2006c). Funding distribution is on a proportional basis among hospital groups (based upon contextual divisions; OHA, 2006). Yearly examinations of funding requirements determine if adjustments are necessary (JPPC, 2006c). Concerns about data quality collected from various hospital departments continued, so the rates and volumes formula did not calculate some units such as emergency care (JPPC, 2006c).

The first *Hospital Accountability Agreement 2007-08* issued by the MOHLTC (2007b) and signed by administrators at each acute-care institution outlined specific clinical and financial performance obligations hospitals were required to meet. It was uncertain whether hospitals captured some or any of the data required for the 2007-2008 fiscal reporting period. Parkinson et al. (2007) noted that the current fiscal measurements developed by the MOHLTC were not appropriate for Ontario acute-care hospitals because the hospitals were nonprofit and financial success was not an aspiration of hospital administrators.

Because the single-payer formula exists for Ontario hospitals, ownership is not a large consideration for organizational efficiencies. The Ontario government funding formulas developed for the system-wide application of health-care delivery are a mix of

hospital sizes, types, and locations. When examining performance measurements, consideration of resource availability and hospital contexts is necessary. Whether different contextual factors found in hospital groupings had an impact upon the acute-care strategic process was unknown.

Conclusion

The historical development of the Medicare system in Canada, while following the requirements of the Canada Health Act, reflects a diverse approach of health-care system organizational approaches, accountability methodologies, funding formulas, and community relationships (Lomas, 1997). Ontario is the last remaining province where each individual hospital maintains an independent board of governors (Hanlon, 2001a; Sinclair et al., 2005). Presently, hospital administrators have the ability to determine how to apply their global funding to program areas that meet the needs of their patient populations (OHA, n.d.). With the introduction of the LHINs into the Ontario health-care scenario, how the regional authority determined the delivery of health care might be significantly different from the ideas of hospital administrators (McKillop, 2004). Thus, it was uncertain whose priorities drove the strategic plan and whether strategy was intended, emergent, or imposed (Denis, 2004; Glouberman & Mintzberg, 2001a; Hanlon, 2001a; Mintzberg & McHugh, 1985; Mintzberg & Waters, 1985; OHA, 2004a).

The strategy literature has in large part developed from the perspective of the for-profit, competitive environment in the United States. The modalities recommended through these lenses contained some relevancy in the Ontario system as Ontario acute-care institutions competed with each other for scarce resources, both financial and

human. The critical difference was Ontario hospitals function under a single-payer funder and government designed the public policy for which all hospitals must comply.

The three common strategic planning principles are environmental assessment, strategy formation, and implementation (Jennings & Disney, 2006; Kaleba, 2006; Zuckerman, 2003). The ability to utilize the three principles strongly depended upon the external relationships hospitals had with their regional LHINs (Pfeffer & Salancik, 2003) and internal relationships with middle managers (primarily nursing) and physicians (Noda & Bower, 1996).

Although research exists on strategic priority setting in Ontario hospitals (Brown et al., 2005, 2006; Martin et al., 2003), there was no consistency on whether the strategic priority setting should be at the individual hospital level or on a regional or full system level. Yap et al. (2005) admitted that only a small percentage of the hospitals in Ontario used portions of the previously developed performance-measuring scorecard and a number of intricacies require further understanding to comprehend a wider application of the measurement system. A significant gap exists in the literature on strategic planning, hospital type, and organizational performance within the Ontario acute-care environment.

Summary

The province of Ontario had, in the past, introduced funding formulas that catered toward a business-type environment (Ladak, 1998) promoting cost efficiencies and patient-care effectiveness. So far, the funding formulas had not resulted in the desired effects, which led to the introduction of another funding formula. The MOHLTC using the latest formula, Rate and Volume Equity Funding Methodology (Ladak; Ladak & Pink, 1997), combined with a multiyear approach expected hospitals to receive

reasonable funding according to the patient acuity, location, and efficiencies shown to date (JPPC, 2006c). Members of the MOHLTC recognized there were specific funding requirements dependent upon the type of hospital and location and factored this information into the compensation formulas.

The literature review contained numerous thoughts on the theoretical development of health-care strategy in Ontario; still a deficiency of literature exists on the practical application of such strategies. A literature review on the context of the Ontario health-care system, as well as the relatively new development of performance indicators, plainly revealed there were large discrepancies between MOHLTC expectations and individual hospital administrators' and boards' outcomes. No literature was available that contained an explanation of how Ontario hospital administrators utilized the directions provided by the MOHLTC or the LHIN within the strategic planning process.

An expectation of the MOHLTC was that hospital administrators would meet performance measures, highlighting efficiencies while delivering first-rate patient care. In 1998, introduction of the balanced scorecard approach with systemic indicators for patient-care delivery promoted a methodology to track performance (Pink et al., 2001; Yap et al., 2005). Although numerous references to the balanced scorecard existed in the literature from the U.S. health-care perspective, grossly underrepresented in the literature was a Canadian application. Except for three articles (L. Chan, 2006; Harber, 1998; Parkinson et al., 2007), the creators of the Ontario health-care performance design had written all the other literature sources on the balanced scorecard as applicable in Canada

and Ontario in particular (G. R. Baker & Pink, 1995; G. R. Baker, Brooks et al., 1998; Pink et al., 2001; Yap et al., 2005).

Understanding the strategy process that hospital leaders undertook might become more critical as the province moves toward regionalization of funding envelopes. Without comprehending how hospital leaders did or did not undertake a strategic method for delivering health-care in their jurisdiction, underperformance, and failure of cost efficiencies might continue to occur. The directors of the LHINs might be unable to discern why hospital administrators took a specific strategic direction when responding to funding changes and constant disruptions in their working environments while maintaining complex health-care delivery. Identified gaps between the theoretical and the practical application of strategy could identify whether the strategic initiatives undertaken in the Ontario system were relevant for the environment or whether a different perspective was necessary.

Gathering information on the strategy planning process of acute-care hospitals in Ontario required a mixed-methodology approach as outlined in chapter 3. Because the perception of strategic planning is uncertain at the acute-care administrative level, qualitative sessions with senior management teams exposed different viewpoints of strategy. Information gathered from qualitative sessions provided direction on common points shared between hospital leaders and then was further examined through a quantitative survey. Outlined in chapter 3 is the rationale of using the mixed-methods approach instead of other research methods, the interview techniques for the qualitative phase, and the quantitative statistical analysis methods.

CHAPTER 3: METHOD

Little or no research exists on the strategic and decision making actions of Ontario hospital senior administrators, and it is unclear whether government policy translates into strategic decisions at the hospital level, which in turn creates greater efficiencies in the hospital and collectively in the system. The first purpose of the exploratory mixed-method study was to understand if and how acute-care hospital administrators used strategic planning, and what success, if any, the administrators attained in meeting organizational performance goals. The second purpose of the study was to determine relationships, if any, between strategy, hospital type (academic, community, and small), and organizational performance at the acute-care hospital level. Organizational performance used six measurements: financial current ratio, full-time nursing equivalents, and readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure. The chapter contains a discussion on the methodology, including the topics of research design, population, instrumentation, data collection, data analysis, and validity.

Research Questions and Hypotheses

Determining the best method to frame research questions for an exploratory mixed-method study is difficult (Creswell, 2003b; Creswell & Plano-Clark, 2007). As the study was a sequential study using a two-phase approach, it was difficult to hypothesize strategic planning outcomes, as results from the qualitative phase were important in developing the quantitative questions. Using the order of the study, the research questions outlined the information sought in the study.

The purpose of the research was to understand how administrators of acute-care hospitals in Ontario use strategic planning. In creating the foundation, the purpose was broken down into five questions:

1. What is the content and context of strategic planning from the perspective of hospital administrators and does strategic planning within this environment emulate other strategic planning methods or theories?
2. What do hospital administrators view as best practices in strategic planning (presuming that the planning takes place)?
3. What differences in strategic planning and views as best practice to achieve performance goals exist between types of hospitals based on hospital type (academic, community, and small)?
4. What is the correlation, if any, between strategic planning and hospital performance in Ontario acute-care hospitals?
5. Which types of hospital performs better than others and which, if any, of the three of the strategic planning principles (environmental scanning, strategy formation, and implementation) are used?

Based upon the literature review and historical evolution of the Ontario health-care system, the study involved an attempt to answer three preliminary hypotheses. The hypotheses referred to research questions: whether an identifiable strategic planning framework existed (Research Question 5), if the results of such a framework was associated with organizational performance, and whether hospital type had any influence on organizational performance (Research Question 4).

The literature review in chapter 2 included a discussion on the effect that organizational context plays upon the development of hospital strategic planning capabilities, organizational performance, and efficiency. The research questions captured the concept of hospital type as the provincial government determines the size, patient acuity, and geographic location of hospitals and it was uncertain whether these differences contributed to variations in strategic planning. The qualitative research questions (Research Questions 1, 2, and 3) led to the development of three hypotheses regarding the relationships between the independent and the dependent variables and provided the foundation for the quantitative instrument. An identifiable strategic planning framework has a specific planning process (Mintzberg, 1994). The process could have been unique to the hospital involved; however, specific steps taken within the process captured the movement toward reaching goals. The first hypothesis explores whether relationships exist between strategic planning frameworks and hospital type incorporating Research Question 5.

H1₀: Hospital type (academic, community, and small) is not related to use of an identifiable strategic planning framework.

H1: Hospital type (academic, community, and small) is related to use of an identifiable strategic planning framework.

To determine whether the different independent variables (strategic planning and hospital type) affected hospital performance as the dependent variable, questions in the second and third hypothesis (as reflecting Research Question 4) questioned whether the interaction of hospital performance (financial current ratio, full-time equivalent nursing

positions, readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure) differed between strategic planning and hospital type.

H2₀: Hospital type (academic, community, and small) is not related to hospital performance.

H2: Hospital type (academic, community, and small) is related to hospital performance.

H3₀: There is no relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

H3: There is a relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

Support or revisions of the preliminary hypotheses were dependent upon the data gathered from the qualitative research.

Appropriateness of Design

Exploratory mixed-methods research is an approach to a research study that combines elements of both qualitative and quantitative paradigms within the research process (Creswell, 2003b; Creswell & Plano-Clark, 2007; Tashakkori & Teddlie, 1998). As a methodology, mixed-method studies collect, analyze, and combine data within a single study (Creswell & Plano-Clark). A mixed-method study permits the researcher to approach the study subject from a variety of angles. Mixed-method study is gaining recognition as a valuable method in health research (Adamson, 2005; Steckler, McLeroy, Goodman, Bird, & McCormick, 1992).

A mixed-methodology was not the only research design considered for the study. Measuring strategic planning and organizational performance required an exploration of the subject matter from the perspective of those who perform the task in order to gain a greater perspective of the field from their perspective. A case study methodology might have provided an in-depth examination of the strategic processes from limited hospitals. A straight qualitative method would not have permitted a correlation of strategy and performance, which was necessary to determine whether the strategy was effective. A case study method would only involve an examination into specific hospitals and would not capture generalizations across large numbers of institutions.

The study design could have included a quantitative survey approach to measure relationships between strategic planning variables. Because strategic planning research on Ontario acute-hospitals does not exist, it was difficult to validate a pure quantitative approach to explain the relationships between strategy and performance without understanding the phenomenon at the individual level. To create a quantitative instrument that would reflect the perceived realities of strategic planning from the hospital administrators' perspective, a mixed-methods study was most appropriate.

Several approaches were available to apply mixed-methods into the study design: triangulation design, sequential design, and embedded design. Triangulation design involves the use of qualitative and quantitative methods concurrently during the research with equal emphasis on each research technique (Creswell & Plano-Clark, 2007). The sequential method involves finding one design phase (for example, qualitative) used before the other phase and results in an unequal weighting of data gathered during the research techniques (Creswell, 2003b). An embedded design indicates that the qualitative

research method is rooted in the quantitative instrument used to collect data (Tashakkori & Teddlie, 1998).

Choosing the type of mixed-method study to use in the research process requires the consideration of factors such as timing, how to weigh data from the collection methods, and different mixing techniques (Creswell & Plano-Clark, 2007). As the intent of the research design was to understand how acute-care hospital administrators perceived strategy within the environmental setting, an exploratory study was most appropriate. The exploratory study is a two-phase approach and is sequential in nature. The mixed-method exploratory study starts with collecting qualitative data and using information gathered during that stage, whereas a quantitative instrument tests an emerging theory or concept (Creswell & Plano-Clark).

Using qualitative data to create a quantitative instrument is a variant of the exploratory design method known as an instrument development model (Creswell & Plano-Clark, 2007, p. 77). Creswell and Plano-Clark noted that in the instrument development model, the researcher examines the research topic through discussions with a limited number of individuals. Results from the discussions guide the development of questions for a quantitative survey instrument. The second phase of the research requires validation of the instrument quantitatively. The instrument development model weighs quantitative data higher than it weighs qualitative data.

A mixed-method exploratory study involves several challenges (Creswell & Plano-Clark, 2007). A common criticism leveled at mixed-methods studies is the lack of integration between the two sets of data (Adamson, 2005; Bryman, 2007, Creswell & Plano-Clark), resulting in a lack of recognition regarding the importance of the data

collected. Due to the multiphase approach of the research, longer timelines are necessary and require greater consideration when developing the conceptual model of the research (Creswell & Plano-Clark). Depending on the population size, the same individuals might participate in both the qualitative and the quantitative research phases. There is difficulty providing internal academic review boards with specific descriptive procedures of the quantitative phase because much of the quantitative portion of the research is dependent upon the qualitative results. The intent of the remainder of the chapter is to address the challenges within the research methodology and design. A framework describing the research process appears in Appendix C.

Population

Acute-care hospitals exist across Canada. Unlike in the United States, the Canadian government does not allow any form of private health care in the acute-care setting. With the exception of military hospitals, all acute-care hospitals receive funding from the respective Ministries of Health. The hospitals in the province of Ontario are different from the hospitals in the other nine provinces in that each hospital maintains an independent board of directors responsible for the governance of the institution (Hanlon, 2001a). All other provinces have established regional health authorities that determine the strategic direction of the acute-care centers (Lomas, Woods, et al., 1997). For this reason, the broad population of the study was all acute-care hospitals across Canada. There were enough differences between the governance structures of Ontario hospitals from other acute-care institutions in the country to support using only acute-care organizations in the province of Ontario as the study population.

The province of Ontario has 136 acute-care hospitals classified into three groups: small, community, and academic or teaching (MOHLTC, 2006b). After hospital umbrella organizations received consideration, the province had 119 acute-care hospital leadership teams. The province has several addiction and mental health institutions, as well as chronic care and rehabilitation hospitals. The expected performance requirements and funding from the MOHLTC for the other hospital organizations were different from the acute-care hospitals, and the differences could change the strategic planning methods used by hospitals. Because the type of care was different from acute-care institutions, the hospital population considered for the study removed the addictions and chronic-care hospitals. Excluding administration teams participating in the focus group sessions and survey pilot, all other hospital administrators received a request to participate in the quantitative research.

Geographic Location

The study was limited to the province of Ontario, Canada. Ontario is the second largest province in Canada and the 2006 census reported Ontario had more than 12 million residents, representing 40% of the total population of the country (Statistics Canada, 2007). The greatest population base in the province resides near the Great Lakes (80%), and the remainder of the population is scattered throughout the northern and eastern parts of the province, representing the greatest portion of the provincial landmass (Province of Ontario, 2007). The province covers more than one million square miles (Province of Ontario). Over 190,000 individuals indicated on the 2001 census that they were Aboriginal, First Nations, Métis, or Inuit (Statistics Canada, 2007), and many First

Nations communities in Northern Ontario are only accessible by bush plane, boat, or winter road when the lakes freeze over.

Human Subjects

To ensure that no harm came to any participants in the study, adherence to certain standards in the research protocol occurred. The study had no anticipated adverse effects or risks and did not involve compromising the privacy of the participants. All participants signed informed consent forms prior to the focus group sessions in the qualitative phase of the study and signified their agreement to participate on the survey Web site in the quantitative phase. Participants had the right to withdraw from the study at any time with no adverse affects on relationships with the researcher or supporting organizations. All participants received an assurance of confidentiality.

Research Design

The primary purpose of the study was to understand what hospital senior management teams determined was strategic planning, if administrators used strategic planning to meet expected government performance measures, and whether success occurred in meeting the goals of strategic planning. To answer the research questions, a pragmatic research view was necessary, where blended research methodologies using a mixed-method exploratory study resulted in a holistic view of the problem (Creswell & Plano-Clark, 2007; Tashakkori & Teddlie, 1998). Although researchers had conducted studies on strategic planning in acute-care settings in other countries (Chun-Chang & Feng-Chuan, 2005; Cueille, 2006; Torgovicky et al., 2005), no studies existed using interviews or surveys to identify the concept of strategic planning from the hospital executives' prerogative in the Ontario acute-care hospital type. The focus of research on

strategic planning in the United States and Great Britain was on quasi-competitive health-care environments. This was not the case in a single-payer system as found in Canada. Because the environment of the study was different from existing research, an exploratory study was the appropriate methodology for investigating the research problems.

A mixed-method exploratory study met the needs of the research in multiple ways. Existing strategic planning literature provided concepts and variables from other health-care environments, but the applicability to the unique characteristics of the Ontario acute-care setting was not clear. A mixed-method exploratory study that began qualitatively was effective in studying a phenomenon when instrument development was necessary and variables and their importance were unknown (Creswell & Plano-Clark, 2007). A mixed-method exploratory study was appropriate for generalizing the results to different groups within the study structure (Morgan, 1998).

The research involved an exploration into not only the perspective of acute-care senior administration teams and what the administrators believed were important variables in the strategic planning process, but also whether distinct differences existed in how different hospitals planned strategically based upon environmental influences that could be classified into categories. The mixed-method exploratory study involved building on data from phase one to answer the research questions on a greater scale in the second phase. The qualitative data guided the development of the quantitative questions and both data collection methods connected through the creation of the instrument items (Creswell & Plano-Clark, 2007).

To describe the research method, the presentation of the components of the study appears in two sections: the qualitative and quantitative sections. To facilitate proper research techniques, Dr. Michel Bedard, Public Health Department at Lakehead University, in Thunder Bay, Ontario, agreed to consultations during the research development (see Appendix D for confidentiality statement). As there was a personal relocation by the researcher during the data collecting process, Dr. Laurel Duquette at the University of Toronto assisted with the data analysis.

Qualitative Research Design

Qualitative Research Methodology

The first phase (P1) of the study involved the use of focus group sessions to gather qualitative data. The focus group included predetermined questions to open the discussion while giving control to the participants to respond and direct the conversation (see Appendix H; Morse & Field, 1995). The format was a simple interview process with open-ended questions designed to gain understanding of how the participants viewed strategic planning from an individual as well as an institutional perspective. The sessions followed best practices in that the interviewer was an active listener, had well-prepared questions focusing the conversation on the larger research questions, and permitted the participants to offer multiple answers to enrich the data collected (Dilley, 2000).

As this phase of the study involved not only trying to understand the philosophical framework of hospital administrators toward strategy, but also exploring adherence to certain methodologies, Schutz's (1972) theory of social phenomenology provided a guideline during the research process:

1. The postulate of logical consistency: The researcher must establish the highest degree of clarity of the conceptual framework and method applied, and these must follow the principles of formal logic.
2. The postulate of subjective interpretation: The model must be grounded in the subjective meaning the action had for the “actor.”
3. The postulate of adequacy: There must be consistency between the researcher’s constructs and typifications and those found in common-sense experience. The model must be recognizable and understood by the “actors” within everyday life. (Fereday & Muir-Cochrane, 2006, pp. 2-3)

An exploration of strategic planning from the perspective of participants within the realities of their environment followed the postulates. Using strategic planning information gathered during the literature review process and application from the practitioners’ viewpoint provided the baseline in constructing the quantitative portion of the study. Data gathered from the sessions were transcribed and analyzed using NVivo 8 software to perform content analysis. Two independent raters recoded data sections to determine validity and reliability of the content analysis.

Qualitative Sampling Frame

The population of strategic planning in acute-care hospitals included all hospitals in Canada. The study population was limited to the province of Ontario. The sampling frame was the same as the study population. Ontario has 136 incorporated hospitals. Further evaluation indicated that several hospital organizations had created leadership teams to manage several small hospitals. Thus, the total number of hospital senior teams in the province was 119. As the primary purpose of the study was to understand if senior

administration teams used strategic planning to meet expected performance outcomes, the study began P1 through nonrandomized focus groups of senior management teams using 4 of the 119 hospitals (Sample Group 1). Using purposive sampling, senior management teams from one academic hospital, one community hospital in a larger urban area, and two small hospitals received an invitation to participate (see Appendix E for Permission to use the Premises). For P1, hospitals selected were in southwestern Ontario to avoid introducing bias during the focus groups, as professional relationships existed with senior administrative teams in northwestern Ontario.

The data collection process involved scheduling four focus groups sessions, one with each hospital; additional focus groups were not necessary to attain saturation. Saturation exists when collected data reveal no new information (Morse, 1995; Tuckett, 2004). In contrast with quantitative methods, qualitative methods contain no specific guidelines to determine the sample size needed to achieve saturation. Achieving saturation in a qualitative study requires a researcher to use a narrow focus of inquiry and delve into specific areas of interest (Morse). Although researchers use information redundancy as a method to indicate achievement of saturation, frequency is not as important an indicator as the richness of the data collected (Tuckett). Saturation occurred when participants' detailed descriptions of strategic planning within their hospital environment did not provide any new methodologies and enough data demonstrated the foundation of a convincing theory (Morse).

Qualitative Informed Consent and Confidentiality

As part of the requirements of the dissertation proposal, administrators of the hospitals designated for the qualitative sessions received a Permission to Use Premises

letter (see Appendix E) which were returned signed. Upon initiation of the research, each member of the senior administration teams who agreed to participate in the interview process received a letter that described the research in its entirety and the purpose of the qualitative P1 (see Appendix F). All participants had the option not to participate in the focus groups. Signed consent forms (see Appendix G) were collected at the time of the focus groups. As the purpose of P1 was to gain an understanding of the senior hospital management members' approach to strategic planning, the focus group transcripts did not identify any participant. The consensus expressed by the senior administration team interviewed formed the content theme. All participants received a consent release form outlining the study, their right to withdraw from the study at any time, and assurances of confidentiality, as well as a request to audio tape-record the focus group session. Potential benefits to the participants for participating in the study were their contribution to a greater understanding of strategic planning at the hospital senior administration level. No risks were identified for individuals participating in the study.

An external digital drive was used to archive the transcripts from the focus groups. Tapes from the original focus groups will remain with the transcripts in a safety deposit box. Consent forms and any hard copies of participant material will be in a locked cabinet for three years and then shredded. Physical destruction of the external drives and tapes will take place three years after the study is complete.

As the community of senior administrators in the province of Ontario is relatively small, maintaining the confidentiality of the hospitals involved in P1 was important so participants would feel comfortable in being honest with their responses. Each focus group received an identifying code (i.e., Senior Management Team [SMT] 01) to

differentiate between the different hospitals participating in P1. Individual participants were not identified; the transcripts contained only the verbal discussion of the focus group session, with no identification of the speakers involved. The participants were not asked to identify themselves at the beginning of the focus group session. The final aggregate data did not include any identifying information regarding which hospitals participated in P1.

Qualitative Data Instrumentation

One of the most important question underlying the current research was why the Ontario provincial government changed the approach to hospital health-care delivery and performance measurement so many times since 1990 (HRSC, 2000; MOHLTC, 2002, 2006b). Because of the rapid pace of change, hospital administrators had difficulty responding and understanding changes, and little time to reflect and anticipate change in their strategic planning. Whether a consistent definition of strategic planning existed was uncertain. These unknowns led to the development of the interview questions (see Appendix H). The interview questions were created in an attempt to understand how hospital senior administrators approached and used strategic planning, who was involved in the strategic planning process, how often the plan was reviewed and revised, and how the strategic plan was monitored to meet organizational goals and performance targets.

The P1 research began with pretesting the interview questions though an expert panel of 4 members. B. Butters, ex-CEO of Tillsonburg Hospital in Tillsonburg, Ontario, agreed to head the expert panel. Butters serves with the Canadian Council of Health Services Accreditation. The three other members of the panel included a previous hospital administrator, a previous hospital board member, and a past president of the

OHA. All of the expert panel members had long experience in strategic planning in acute-care institutions. The expert panel members lived in or close to the Greater Toronto area and were able to come to meetings regarding the qualitative questions. The P1 questions included the recommendations for changes made by the expert panel members (see Appendix H).

The qualitative P1 involved the use of focus group sessions to study how hospital administrators understand strategic planning and applied the concepts to their environments. As strategic planning is usually a group activity, the study involved examining group responses to questions related to the planning and performance of the hospital organization. The qualitative phase of the study involved an attempt to understand the strategic planning phenomenon as identified in Research Questions 1 and 2. The research study involved investigating whether hospital administration members could segregate strategic planning into specific methods or theories and if best practices existed.

Qualitative Data Collection Process

Participation in the focus groups occurred on a volunteer basis and no material incentive was offered. The focus group sessions lasted approximately 30 minutes to one hour, depending upon the amount of time afforded by the administrative team. Each focus group session had between four to six participants, depending upon the size of the management team. One hospital organization opened its strategic planning retreat for review. The sessions were audio tape-recorded and each focus group session included a multidirectional microphone. The research introduction letter (see Appendix F) informed interviewees that the transcriptions would not have any identifying features and edited

final transcriptions would not contain references to individuals. The focus group sessions were directed by using Spradley's (1979) Developmental Research Sequence.

Developmental Research Sequence involves starting the session with a broad question and then using the participants' responses to create specific questions on the subject matter to understand the points of view expressed (Spradley, 1979; Todahl, Linville, Smith, Barnes, & Miller, 2006). Field notes captured and documented responses to the questions posed and the conversation that ensued, as well as other details about the participants based on observation.

To facilitate the process, the qualitative portion of the study took place at each of the four hospitals. To make efficient use of time, the interview included all administrative team members in a hospital during the same session in a focus group format. A request to conduct the interview after a weekly senior management team meeting, where all members of the senior team were already gathered, helped to set a convenient time for the participants. The focus group format might have influenced the validity of the method because individual members might not have felt free to offer their opinions on the strategic planning format that their hospital follows. The limitation was not evident during the focus group sessions. P1 involved an examination of what methods the senior management teams use to perform strategic planning and not whether individual administrators believe the methods are effective. Additional focus groups were not necessary to attain saturation. The information gathered in P1 helped to formulate the questions in the second phase of the study (P2).

Qualitative Data Analysis

For the qualitative phase of the study, after each focus group session, the transcription of field notes occurred within seven days of the interviews. Reviewing the tapes soon after each session allowed a review of content by listening to responses to questions and capturing any other observations and thoughts missed in documentation obtained in the focus group session. Transcription of the tapes into text documents used Microsoft Word software. Transcription of the tapes was word-for-word, except for any details that could identify participants. The initial review of the transcript documents was open coded to look for broad trends and develop a basic understanding of the database information. The initial coding method tied the data to the research questions and involved the use of previous literature and concepts identified during the first analysis of the data. This coding phase was targeting concepts of strategic theory, best practices, and differences in the phenomenon due to variations in hospital type, size, and location. Field and review notes were included in the open-coding phase.

Formatting the transcripts into rich-text format enabled an easy transfer to NVivo 8 software to perform content analysis. The participants reviewed the transcripts for verification to ensure that the data collected captured the participants' collective views on strategic planning. After the transcript documents were loaded into the NVivo 8 software, axial coding technique started. Using the original set of initial codes designed from the research questions, the analysis of the data included the use of Spradley's (1979) Semantic Relationships to examine the data for relationships and value.

Spradley's (1979) Semantic Relationships provided a coding methodology (see Table 3) that involved examining data for cause and consequences, interactions, and

processes. The list is adaptable for any culture or situation (Fereday & Muir-Cochrane, 2006; LeCompte, 2000). The list allows data sets structured into phrases and organized into like and unlike items. The result is a taxonomy or classification system.

Reclassifying the taxonomies into patterns provides an opportunity to develop explanations or descriptions of events. Desired outcomes were to obtain both static analysis (a description of the event as it occurs) and phase analysis (the development of actions over time) of the strategy process from the participants' perspectives (Morse & Field, 1995). This form of narrative analysis lent itself to determine if path-dependency was a valid explanation of the strategic process (Neuman, 2006). Using the Spradley system improved the analytic organization of the data and contributed to a mechanical data reduction (Neuman).

The Spradley coding methodology was a guide in developing attributes and nodes in the NVivo 8 program. The use of the NVivo 8 software served to identify attributes about the group interviewed (QSR International, 2002). The information included the type of hospital or geographic location. Attributes assisted in differentiating specific identifying features that provided information when examining the data for generalizations. The NVivo 8 software also permitted the coding of data to include three forms of nodes, free nodes (ideas not yet linked to other ideas), tree nodes (hierarchical structure for ideas), and case nodes (group specific concepts), and then subgroup them to specific identifiers (QSR International). The data analysis process included all three forms of node coding.

Table 3

Spradley's Semantic Relationships

No.	Relationship
1	X is a kind of Y
2	X is a place in Y
3	X is a part of Y
4	X is a result of Y
5	X is a cause of Y
6	X is a reason for doing Y
7	X is a place for doing Y
8	X is used for Y
9	X is a way to do Y
10	X is a stage or step in Y
11	X is a characteristic of Y

Note. From *The Ethnographic Interview* by J. P. Spradley, 1979, p. 111. Copyright 1979 by Thomson Publishing. Reprinted with permission (see Appendix K).

A final analysis of the transcript documents took place through a selective coding procedure. A review of all the data and previous codes one final time helped to ensure that well-developed concepts existed and that an overall organization existed in the analysis. The major themes and generalizations identified through the first two coding reviews guided this portion of the analysis. The NVivo 8 software assayed the nodes and attributes to determine relationships in the data. Using the assay tool, tables can show where specific values appear in the documents. The model tool displays, explores, and explains the data to show relationships between data variables.

Qualitative Data Validity and Reliability

LeCompte and Goetz (1982) raised several concerns on reliability and validity in qualitative research. LeCompte and Goetz identified five areas where external validity was questionable: the status position of the researcher, informant choices, the social context in which the gathering of data occurs, the definitions and delineations of the constructs and their relationships, and the methods of data gathering and analysis. The use of several steps helped to mitigate the validity issue for the qualitative study phase.

To maintain validity of qualitative research, both internally and externally, several authors have recommended using the audit trail (Creswell & Miller, 2000; Donovan & Sanders, 2005; Morse & Field, 1995; Rogers & Cowles, 1993; Tashakkori & Teddlie, 1998). Researchers create the audit trail by documenting the study process through a research log (Creswell & Plano-Clark, 2007). Data collection is chronological, and data analysis procedures clearly described. Thorough documentation to changes in the methodological approach and the rationale behind the changes is necessary (Creswell & Plano-Clark). As focus group sessions progressed, new insights led to changes in some of the questions asked of participants. The research journal contained reports of any changes and the reasons for the changes (Creswell & Plano-Clark). Recording subjective interpretations of events alerts a researcher to the possibility of bias (Morse & Field).

Another step to ensure validity was to compare results from the data collected in the study to previous research found in the literature. Because pragmatism created the basis for the study, theoretical verification of results by other researchers was important to relate other concepts found in similar settings (Morse & Field, 1995). Although no previous studies of strategic planning in Ontario acute-care institutions existed, strategic

planning in acute-care hospitals in other research had similarities in the three principles of environmental scanning, strategy formulation, and implementation. Reviewing study data in previous research highlighted areas where researcher bias had infiltrated the interpretation of results and then allowed the opportunity to correct the biases.

The use of independent raters to review the data collected provided not only face validity during this research phase, but also reliability of the instrument (Neuman, 2006). Two raters were necessary for this portion of the research: one member of the expert panel and a second independent rater within the health-care profession. The expert panel member was a past president of the OHA who had experience in strategic planning at the acute-care level. Due to a personal emergency, this rater had to withdraw from the review process. The second independent rater was completing a doctorate in health-care administration, worked in the Ontario health-care industry, and was familiar with Ontario health-care policy and regulations. The rater reviewed the data transcripts and data analysis to ensure that the results were valid and represented the data collected from the interview process.

Reliability is difficult to achieve in qualitative research due to the lack of standardized controls and an inability to replicate unique situations (Creswell & Plano-Clark, 2007; LeCompte & Goetz, 1982; Tashakkori & Teddlie, 1998). As a way to achieve internal reliability, use of peer examination provided reliability for the data (LeCompte & Goetz). The independent raters received a section of the transcribed data and predetermined codes. A discussion ensued with the independent raters on the how the constructs were identified and any definitions associated with the codes. The independent raters coded a section and determined if they assigned similar or different codes to the

text. The results were then compared against the previously coded study data. The degree of agreement between the raters' coding and the study coding was the basis for determining the reliability of the study. Although differences existed between the independent raters' results and the study data coded results, the differences were used for insights regarding potential predictions, biases, and influences within the setting (LeCompte & Goetz). Discussion took place on any variances found between the previously coded study data and the independent raters' results to develop a consensus on the parameters of the coding design. Consensus was important to assure that the data analysis resulting from the qualitative focus groups was germane to the population studied to create a relevant quantitative survey.

Quantitative Research Design

Quantitative Research Methodology

Quantitative research involves the use of statistical data to make inferences about the population from which data came (Creswell, 2003b). The quantitative phase of the study included the use of data collected in the qualitative instrument focusing on Research Questions 1 and 2 and involved a quantitative instrument designed to understand any relationships as identified in Research Questions 3, 4, and 5. The quantitative phase (P2) involved a cross-sectional survey in a Likert-type multiple-response design to gather data from the health administrator population. A cross-sectional survey was appropriate in this setting because the study involved making inferences about the behaviors of a certain population and if associations existed between these behaviors (Gray, Williamson, Karp, & Dalphin, 2007).

Cross-sectional research was appropriate for the study, as the funding formulary provided to acute-care hospitals had changed over the past year. A longitudinal study would not have provided accurate information because the expectations of organizational performance and hospital accountabilities did not previously exist in the same manner. The survey used in the study was an exploratory study in that the research involved an examination into three areas of interest: whether broad trends in strategic planning existed in hospitals; if the performance of strategic planning differed depending on the hospitals' size, patient acuity level, or geographic location; and if hospital performance and strategic planning related to each other.

The P2 research study developed from the content analysis from the P1 study. Data collected from the P1 study and strategic planning principles gathered from existing theoretical concepts provided the framework for the development of the P2 survey questions. The survey went through two validity checks: the expert panel reviewed questions to ensure relevancy and a piloting process using hospital administrators at one Ontario acute-care hospital. Hospital leaders at one hospital were requested to review the draft survey in an electronic format. In the piloting process, leaders were requested to examine the survey for readability, a logical presentation of questions, and interpretation consistency. The pilot hospital leaders were excluded from the final survey distribution to remove any potential history bias. A request for participation to all hospital executives took place using a survey hosted on SurveyMonkey.com. Consolidation of the variables involved using factor analysis so that the analysis used meaningful combined factors or variables. SPSS software facilitated data analysis. The original plan was to use a sequential regression analysis to identify whether relationships existed between the

independent variables of strategic planning and hospital type and the dependent variable of organizational performance. Due to large missing data responses, analysis of variance (ANOVA) and nonparametric data analysis were implemented. The study included the use of a one-way ANOVA to test for preference differences among the hospital types (academic, community, and small) and the five strategic planning patterns.

Organizational Performance Measurements

Through the 14 provincial LHINs, the Ministry of Health and Long-Term Care (MOHLTC) had signed hospital accountability agreements with each acute-care institution in the province (MOHLTC, 2007b). Within the accountability agreements were several performance indicators measuring hospital performance both clinically and financially. Using these existing measurements, the quantitative research phase examined the importance to hospital senior management teams of government measures and performance expectations when planning hospital strategy as per hypothesis H₁.

Only in the past 10 years had the MOHLTC begun to collect acute-care hospital organizational performance data. To use performance measurements that were as applicable as possible to all acute-care hospitals regardless of size, the study included the use of three required MOHLTC performance indicators. The indicators captured data from the 2007-2008 fiscal year, which represented the most recent data collected by hospitals, and incorporated the new accountability to the regional Local Health Integrated Networks (LHINs). One performance indicator was the percentage of full-time nurses on staff. The ministry target was that 70% of all nurses employed in acute-care hospitals must be full-time equivalents. For academic and community hospitals, the performance

corridor was negotiated at target minus 1%, and for small hospitals, the performance corridor was negotiated target minus 3% (JPPC, 2006a).

The MOHLTC and the hospital leaders recognized that interhospital variations in accounting practices had the potential of seriously compromising the comparability of financial health indicators (JPPC, 2006b). Thus, only the current ratio was appropriate because it had greater reliability due to specific accounting determinants that all organizations utilize. The current ratio measured liquidity of the hospital assets. The target and corridor for all hospitals was 0.8 to $2.0 \pm 10\%$.

Because hospitals have a variety of patient acuity levels, it can be difficult to find clinical indicators that all hospitals measure. Case-mix groups that the majority of hospitals admit into their acute-care sites are myocardial infarctions, chronic bronchitis, chronic heart failure, and diabetes. Although the MOHLTC requests monitoring of performance indicators of other case-mix groups, all hospitals will admit and treat patients with myocardial infarctions, chronic bronchitis, heart failure, and diabetes. It is important to know these clinical indicators as this information informs hospital administrators and clinicians of how well patients are managing once discharged from acute care. The MOHLTC was interested in readmission rates for all these particular case-mix groups.

$$\text{Risk of Readmission} = \frac{\text{Observed} - \text{Expected Readmission Rate}}{\text{Proportion of Patients With Unplanned Readmissions Within Within 30 Days} - \text{Proportion of Readmissions Within 30 Days}}$$

The definition of rate of readmission for selected case-mix groups is the “number of patients readmitted to the same Hospital for an unplanned readmission within 30 days

from the index admission, compared to the expected number of readmissions based on the facility's case mix" (JPPC, 2006a, p. 32).

Table 4

Sample of Performance Corridor Ceilings

Hospital cases	Readmit rate is not to exceed expected rate by more than
100	10.0%
200	7.1%
300	5.8%
500	4.5%
700	3.8%
1000	3.2%
1500	2.6%
2000	2.2%
2500	2.0%
4000	1.6%
6000	13%

Note. Adapted from "Schedule B," by Joint Policy and Planning Committee, 2006a, Hospital Accountability Template Agreement, p. 34.

The performance corridor was the upper control limit on the amount by which the hospital's readmission rate surpassed the expected rate. The width of the corridor related to the hospital's annual number of eligible cases. The width was three times the standard deviation of the hospital's expected readmission rate divided by the square root of the hospital's number of eligible cases (JPPC, 2006a). Table 4 shows a sample performance

corridor ceiling for hospitals with the median same-hospital readmission rate (12.86 percent) by various numbers of eligible cases. Hospital specific corridors were available to hospital administrators through the Ministry web enabling reporting system.

Hospital Type

Phase 2 of the research also included an examination of what steps, if any, senior management teams took to build performance measurements into the strategy of hospital performance. The intention was to determine, as asked in H1₀ and H2₀, if hospital type and patient acuity levels created different responses in strategic planning and organizational performance. To capture whether generalizations of hospital type existed, the quantitative phase used current OHA hospital categories to identify whether the hospital was a small, community, or academic hospital. Further identification of hospitals occurred using the number of acute-care beds and if the hospital was in the Greater Toronto Area. Some community hospitals located within the Greater Toronto Area have close ties to academic institutions, improving the delivery of patient care and possibly affecting clinical performance ratings. Other community hospital locations were at considerable distances from larger hospitals and might be the only major tertiary center for that region.

Quantitative Sampling Frame

As discussed earlier in this chapter, the general population was acute-care hospitals in Canada and the study population was the acute-care hospitals in Ontario. The sampling frame for P2 was the same as the study population. The sample for the quantitative phase consisted of the hospital administrators who participated in the survey.

Strategic planning and implementation is a group effort (Mintzberg, 1994). Senior administration teams vary in size depending on the size of the hospital, and a variety of management and health-care professionals comprise the teams (chief nursing officers [CNOs], chiefs of medical staff). Most hospital administrations have individuals with a wide range of experience in the education and implementation of strategic planning. To gain an appreciation of what skills the senior administrators brought to strategic planning, it was necessary to involve as many individuals as possible in the survey process. To gain as large a response as possible, the P2 study extended to all acute-care hospitals in Ontario with the exception of the four hospitals used in the qualitative P1 and the one hospital used in the piloting of the P2 instrument; thus, 114 hospital leader groups received an invitation to participate in the survey. The P1 study participants were excluded because the P2 instrument was a reiteration of their experiences and observations of strategic planning. The survey pilot group was excluded as improvements to the instrument were made based upon their observations, and the pilot group was preexposed to study matter and open for bias in the study data collection.

Green (1991) and Tabachnick and Fidell (2007) recommended researchers use $N \geq 50 + 8m$ (where m is the number of independent variables) to calculate sample size in order to test the multiple correlation. The equation includes an assumption of a medium-sized relationship between the independent and the dependent variables, $\alpha = .05$ and $\beta = .20$ (Green). This study had two independent variables: strategic planning and hospital type (patient acuity level, hospital size, and geographic location). Thus, the formula was $N \geq 50 + 8(2)$; $N = 66$. The number of hospitals with returned surveys should not have been below 66. Because it was uncertain whether the dependent variable was of a normal

distribution, the study required as high a case to independent variable response rate as possible (Tabachnick & Fidell). As the study involved examining whether inferred generalizations were possible from the data based upon type of hospital, as large a response rate as possible from participants was preferred. Generalizations regarding strategy applied to hospital type (academic, community, and small) were difficult without an adequate representation by different hospitals. As the number of academic hospitals was limited in the province, in order to ensure as high a response rate as possible to identify existing trends, requests to participate in the research process extended to all eligible academic hospitals' senior management teams.

Because the strategic planning team develops one specific plan for the acute-care institution, the unit of analysis was the hospital. A finite number of hospitals existed in the province (136 with 119 hospital leadership teams); thus, all hospital administrators except for those institutions whose teams participated in the focus groups in P1 and the pilot of the survey (Study Groups 1 and 2) received invitations to participate in the study (114 valid leadership teams). While the process involved significant efforts to encourage all hospital administrators to participate in the survey research, an expectation of 100% participation was unrealistic.

To maximize the number of participants, Ontario Hospital Association (OHA) directors agreed to support the research initiative. Similar to the letter sent to the four hospitals identified for the qualitative P1 (see Appendix F), the directors of OHA agreed to send acute-care senior administration teams a letter of support for the research. The letter included a request that the administrative team members participate in the survey (see Appendix I). Each hospital administrator received the letter of support attached to

information on how to access the Web-based survey. In return, the OHA will receive the aggregate research results to use in its own organizational work and to distribute to member hospitals. The OHA or individual hospitals will not receive any information that identifies hospitals or individual participants.

Quantitative Informed Consent and Confidentiality

In P2, each administrative assistant of the hospital CEO received a letter for distribution only to senior administration team members (see Appendix F). The letter detailed the purpose of the study and requested participation by the members of the senior administration teams. Participation was voluntary and included no material incentive. The introductory letter included information regarding confidentiality, as well as instructions on how to access the survey site (see Appendix F).

Survey data were gathered online using Surveymonkey.com, a well-established and popular survey Web site. Surveymonkey.com also had the capability of hosting a consent form. After participants had entered the Web site as directed on the introductory letter, a page outlining the purpose of the study with an associated consent form (see Appendix G) appeared. Participants had to complete the consent form to move forward into the survey questions. The host server at Surveymonkey.com was secure and digitally protected.

While the identity of the participants remained unknown, it was critical for the research process to include the identity of the participant's hospital. To protect the anonymity of the participant, the introductory letter included instructions for the participant to enter on the survey form an alphanumeric descriptor in a predesignated field indicating the appropriate hospital. For example, preassigned to an academic

hospital was an alphanumeric descriptor of A1; a community hospital was C1; and a small hospital was S1. The alphanumeric descriptor assigned to hospitals was dependent upon type. At no time did the data reflect the identity of the individual respondent, only the respondent's hospital. To ensure the validity and reliability of the data collected, each participant was asked to confirm his or her role as a senior hospital administrator.

Distribution of study results will involve the use of two formats without any identifying indicators. First, each acute-care hospital will receive an executive summary of the results and conclusions of the study. Second, the OHA will receive the aggregate data collected from the study and can share specifics of the study results and conclusions with their hospital members.

Data Instrumentation

Several authors leveled criticism at mixed-methods researchers for poorly integrating qualitative and quantitative data within the research design (Adamson, 2005; Bryman, 2007, Creswell & Plano-Clark, 2007). The research in the study was reliant upon the use of qualitative data to create a valid quantitative instrument. Data gathered during the focus groups ensured that collected information was relevant for the survey as well as appropriate for the purpose of the research (Morgan, 1998; Steckler et al., 1992).

The P2 Senior Management Team Survey (SMTS) was developed from the information gathered from the P1 focus group sessions, from other strategy surveys focusing on performance measurement, and from literature that was particular to this population. A Likert-type survey approach was used for the 52 questions (see Appendix A for prototype survey). No absolute rule exists on what the length of a survey should be (Neuman, 2006). The number of questions relied on the different thematic components

that arose from the qualitative focus groups and captured the components of the research questions and hypotheses (Bowling, 2005; Saris & Gallhofer, 2007). Because the study included five research questions and two independent variables, a variety of questions were necessary in the SMTS to obtain enough data to determine if correlations existed. Phrasing of questions was in positive and negative answer directions to ensure the rating to the answers was consistent (Saris & Gallhofer).

Scale development uses theoretical concepts or conceptual frameworks to operationalize constructs to the phenomenon (DeVellis, 1991). The conceptual framework developed from the literature review (see Figure 1), research questions, and hypotheses provided the guidance in developing the instrument scale. A six-point scale was used so the weighing of answers was consistent and to permit a neutral zone (Neutens & Rubinson, 2002). In recognition that only hospitals of a specific size can answer some organizational performance measurement questions, the survey included several different types of questions to examine organizational performance and strategic planning. A prototype survey appears in Appendix A.

Because the instrument was original, pretesting and piloting of the survey tool was necessary to ensure reliability and validity. A two-stage testing process was undertaken. In stage one, the same expert panel used to pretest the qualitative questions also pretested the survey. The use of the same panel was to ensure that questions reflected the information gathered from the focus group sessions and that the questions were relevant to the potential participants (Andrews, Nonnecke, & Preece, 2003). The pretest examined the survey for redundancy and item reduction. The concept-retention approach

selects items from the important elements identified in the qualitative focus groups while shortening the number of questions (Beaton, Wright, & Katz, 2005).

After making all recommended changes, a request went to one hospital administration team (Sample Group 2) to participate in a pilot of the SMTS as it looked on SurveyMonkey.com. The SMTS was given to the pilot participants on paper and electronically so they could write any comments on the readability, the flow of the document, and the amount of time it took to complete the SMTS. The test pilot process of the survey reviewed language and jargon, consistency in question interpretation, logical presentation of questions, and if the survey was aesthetically pleasing to read (Andrews et al., 2003). Pilot participants were not asked to complete the survey; consequently, a Cronbach's alpha was not performed on any of the pilot feedback. Some debate exists regarding the effectiveness of piloting surveys in that respondents might criticize the survey questions without any guidance of what criteria they should be looking for or what could be wrong with question construction (Foddy, 1996; Hunt, Sparkman, & Wilcox, 1982). To pilot the questions, participants received the SMTS with directions on how to review the pilot (Duxbury, 2003). The comments were e-mailed back for review before the final SMTS was developed.

Data Collection Process

SurveyMonkey.com was used to host the final survey. Participants received a letter of introduction to the research (see Appendix F), information on consent and confidentiality (see Appendix G), and instructions on how to access the survey and place the alphanumeric hospital descriptor (see Appendix F). Because the survey used no personal identifiers, a follow-up email was sent to all potential participants through the

CEO's administrative assistant (see Appendix J) 2 weeks after the initial letter requesting their participation.

Although Zhang (2000) recommended that researchers offer alternative means for participants to return surveys (fax or mail), the study only used an online method to complete the survey using SurveyMonkey.com. Hospital administrators are by necessity computer literate and should not have had any difficulty in using the Internet as a tool to complete the survey. The study information sheet (see Appendix F) indicated that the participant could request to have a hard copy of the survey for information purposes or to complete in lieu of the Internet survey.

Researchers are always concerned that the response rate will be unsatisfactory to produce reliable results. Attempts to preempt this probability included a letter from the OHA communicating to hospital administration teams support for the study (see Appendix I). The OHA represents the acute-care hospitals on high-level discussions with the MOHLTC, provides numerous leadership and training opportunities for hospital administrators and staff, and assists hospitals in meeting specific accreditation requirements (OHA, 2008). Information given to the hospital administrators informed the administrator that the results of the study would be available to hospital administrators for their own use. Because of the benefit of the results to the administrators, it was hoped administration team members would cooperate in the study. With the information learned from the study, the OHA might gain important information that might assist the members when negotiating with the MOHLTC for hospital resources.

Quantitative Data Analysis

The data collected in the quantitative phase of the study represented several factors in the strategic planning process. At the beginning of the survey, each participant put in a specific hospital code identifying the hospital as being a small, community, or academic center; the number of beds; and whether the hospital is in the Greater Toronto Area. The information was important when determining whether behaviors were generalizable by hospital size and location. Strategic planning framework questions were developed from the information gathered in P1 and from known strategic planning theoretical models. The MOHLTC and regional LHINs had created organizational performance measurements. Because hospital administrators must respond to the performance measurements as part of the accountability agreements with the LHINs, there should have been awareness by the administrators of whether hospitals were meeting expected goals.

As the data underwent statistical analysis, to improve reliability, the scale alternatives in the Likert-type instrument used for P2 were transferred to a nominal weight of 1 to 6 (Neuman, 2006). Before starting any analysis, data were examined for entry errors using the SurveyMonkey.com software for data-range errors. After the data passed through the SurveyMonkey.com error check, the data were transferred to SPSS Version 16 software. SPSS Version 16 contained components that examined the data for plausible ranges, missing values, and univariate outliers. Surveys submitted with outliers or missing data were omitted. A codebook was created that documented all methods of identifying the assignment of values to the data. The data were then visually inspected, and descriptive analysis was conducted. The analysis included the means, standard

deviations, and a range of scores for the variables in order to determine general trends. Trends were related to the research questions and hypotheses.

Factor Analysis

The inferential data analysis included the use of the research questions and hypotheses as a guide to examine the independent and dependent variable relationships. As it was important to find patterns in the data, factor analysis was used as a data reduction method. The use of factor analysis was to determine the degree that individual items on a scale group around one or more dimensions (Duxbury, 2002). Organization of the factor analysis was in accordance with the independent and dependent variables contained within the research questions and hypotheses. To ensure that variables were sufficiently interconnected, partial correlational statistics were utilized. Factor analysis helped to minimize multicollinearity in the data analysis, preventing the accurate identification of variable relationships (Spicer, 2005). Factor analysis assists in determining reliability in internal consistency and construct validity. Cronbach's alpha was used as an additional reliability check in this section of the data analysis with a desired result of greater than or equal to 0.7.

Regression Analysis

The hospital was the unit of analysis for the study. As hospital administrators were providing the information on the aggregate behavior of their hospital's strategic planning and organizational performance methods, it was necessary to average the results of the respondents for each individual hospital to provide a generalizable perspective. After the factor analysis was completed, the data contributed by senior administrators

were organized by individual hospitals. The responses for each question for each hospital were aggregated and averaged.

Statistical analysis was performed using ANOVA and nonparametric tests. This portion of the data analysis employed SPSS Version 16 software. The study included the use of a one-way ANOVA to test for preference differences among the hospital types (academic, community, and small) and the five strategic planning patterns. There were a large number of *do not know* responses, and these data were considered missing.

Because the study involved examining the influence that strategic planning and hospital type had upon organizational performance, it was necessary to understand the effect size of the variance in the dependent variable associated with the presence of the independent variables (Tabachnick & Fidell, 2007). It was also important to understand how much association hospital type has to organizational performance that also influenced strategic planning within the same population group. The three hypotheses listed earlier examined the relationships between organizational performance, strategic planning, and hospital type. The use of a one-way between-subjects ANOVA; Fisher's exact test; and the Kruskal-Wallis test served to determine if any relationships existed between organizational performance, hospital type, and strategic planning pattern.

Quantitative Data Validity and Reliability

To ensure validity, the pretesting and piloting of the SMTS instrument involved individuals who had or held positions with similar functional duties as the participants participating in the study research. The expert panel included 4 individuals who had held positions where strategic planning was part of their portfolio and the pilot sample group was comprised of individuals involved in hospital strategic planning. As hospital

administrators of Ontario hospitals was the only target population, the pilot group was fully representative of the population.

Content validity of the instrument required that the measurement of a construct represent all aspects of the conceptual definition of that construct (Neuman, 2006). The use of the P1 data results and theoretical definitions assisted in the development of specific conceptual definitions. Placing the definitions in a glossary at the beginning of the survey for participants to refer to provided a consistent understanding of the constructs (see Appendix B). Gaining criterion validity from the pretest and pilot of the instrument provided some independent verification of the relevancy and clarity of the survey questions. Construct validity was obtained through factor analysis to measure that constructs were operating in a consistent manner throughout the survey.

Reliability measures the dependability of results so that the same event happens under identical or similar conditions (Neuman, 2006). The P2 survey used multiple indicators of a variable to increase the number of measurements from the content of a conceptual definition. Several questions about the same construct can compensate for imperfectly worded questions because several measures are unlikely to repeat similar errors. The responses for participants were within a range of six answers, which encouraged the participants to be as specific about their answer as possible. Less specific responses do not capture enough information about the construct (Neuman).

The survey was pretested using an expert panel and piloted at one hospital to ensure that the questions reflected the information gathered during the focus group session and were relevant to the potential participants. Final survey results measured the

internal consistency of the scales using Cronbach's alpha as another measure of reliability (Presser et al., 2004).

Instrument development usually incorporates components of other research instruments that have proven valid through extensive use (Creswell, 2003b). As there were no identified existing instruments measuring strategic planning for the Ontario health-care system, developing instruments was necessary to gather statistical data on the sample. Although Rondeau and Wagar (2003) had developed instruments for measuring human resources in health care, the focus was not on strategic planning and was retrospective in nature. Existing strategic planning research instruments were reviewed for pertinent question to the research, while avoiding questions that pertained to quasi-competitive factors in strategic planning.

Summary

This chapter included a discussion on the methodologies for conducting a mixed-method exploratory study for a section of Ontario health care not well understood. Completing the study required a mixed-method exploratory study with a qualitative phase (P1) and quantitative phase (P2; Creswell & Plano-Clark, 2007). The qualitative phase consisted of four different hospital administrations interviewed in focus group sessions. The information gathered from those focus groups was coded and analyzed using NVivo 8 software. Thematic components resulting from the coded data formed the basis of the quantitative survey.

The survey questions were pretested and piloted for validity (Andrews et al., 2003). All hospital administrators in the remaining 114 acute-care hospital leadership teams in Ontario received an invitation to participate in the Web-based survey. Excepted

were those who participated in the focus groups and the pretesting of the survey document. The survey underwent descriptive analysis, factor analysis (Duxbury, 2002), and one-way between-subjects ANOVA, Fisher's exact test, and the Kruskal-Wallis test (Spicer, 2005). The intention was for the carefully constructed methodologies to ensure the success of the research reliability, validity, and generalization to the population studied. Chapter 4 presents the results of the study.

CHAPTER 4: RESULTS

With the introduction of the regional Local Health Integrated Networks (LHINs), the business model for health care in Ontario has changed. In the past, hospitals had the ability to run deficits and receive additional funding from the Ministry of Health and Long-Term Care (MOHLTC) to make up budget shortfalls (Gehman, 2002). Regional LHINs now provide finite financial resources to acute-care hospitals, and no accommodation exists for budget deficits in the new funding structure. As acute health-care institutions in Ontario signed accountability agreements with their regional LHIN (MOHLTC, 2007b) and were expected to meet certain organizational performance measurements, understanding whether strategic planning was used to move hospital organizations toward specific organizational goals and outcomes is important. It was uncertain whether hospital acute-care leaders used strategic planning within their organizational setting or if the three principles of strategic planning (environmental scanning, strategy formation, and implementation) were employed effectively (Jennings & Disney, 2006; Kaleba, 2006; Zuckerman, 2003).

The first purpose of the mixed-method study was to understand whether acute-care hospital administrators in Ontario used strategic planning, and if so, how the administrators used strategic planning. The second purpose of the study was to determine relationships, if any, between strategy, hospital type, and organizational performance at the acute-care hospital level. Independent variables for the study included strategic planning and hospital type (academic, community, and small). The dependent variable was organizational performance. Measurements determined by the MOHLTC in the *Hospital Accountability Agreement* (2007b) included levels of full-time nurses on staff,

financial current ratio, and readmission rates for myocardial infarction, chronic heart failure, chronic bronchitis, and diabetes.

As the research plan for the study was sequential, this chapter contains three sections: qualitative research, survey development and pilot test of the survey, and quantitative analysis of the survey results. The process of developing a final research instrument involved the use of focus group sessions in the qualitative P1 section and a pilot test of the survey. Strategic planning theory resulted from the focus group sessions and feedback in the pilot test culminating with a quantitative survey. In each section is a discussion of the data collection, methods, validity, and reliability of the processes used for data analysis and an examination of the findings. The results from the qualitative or P1 (qualitative) findings are presented within three research questions. The quantitative instrument development relied upon the findings from the qualitative data collection and existing theoretical literature to determine whether typologies of strategic planning existed within the study group. A discussion of the final two research questions and three hypotheses is in the P2 (quantitative) section.

Qualitative (Phase 1) Study

Phase 1 of the study began with the development of focus group session questions. To gain the necessary understanding of the context of strategic planning from the senior acute-hospital leaders' perspective, the questions needed to be relevant to their current workplace environment. In particular, the first three research questions directed the development of the focus group questions:

Research Question 1: What is the content and context of strategic planning from the perspective of hospital administrators and does strategic planning within this environment emulate other strategic planning methods or theories?

Research Question 2: What do hospital administrators view as best practices in strategic planning (presuming that the planning takes place)?

Research Question 3: What differences in strategic planning and views as best practice to achieve performance goals exist between types of hospitals based on hospital type (academic, community, or small)?

The qualitative portion of the study involved documenting any changes made to questions or methodological approaches, and the rationale behind those changes, in an audit trail. Use of this research journal allowed reflection on insights gained during the data collection process for later comparison against current theoretical literature. During a search of definitions for strategic terms used by the LHINs, the review of the literature revealed several publications distributed by the MOHLTC to the LHINs. These documents highlight views of the government toward expected LHIN leadership actions that ultimately affect system health-care strategic planning at the regional level (Ardal, Butler, & Edwards, 2006, 2007; Ardal, Butler, Edwards, & Lawrie, 2006a, 2006b, 2006c; Ardal, Butler, Hohenadel, & Olsen, 2008). Whether the LHIN administration, in return, will transfer some expectations to hospital senior leaders to perform their own strategic planning in a complementary fashion is uncertain. While the MOHLTC developed this tool for the LHINs, a review of the OHA or MOHLTC Web sites did not locate comparable tools for senior acute-care hospital leaders.

Expert Panel

To ensure that the questions developed for the focus group sessions were not only applicable to the research questions but also relevant to the focus group participants, an expert panel assembled to evaluate the questions and recommend changes. Because the information gathered from P1 data provided the foundation to develop the P2 survey questions, ensuring that the questions asked in the qualitative sessions were relevant to the experiences of the hospital leaders was important. A panel of individuals who have performed strategic planning within the Ontario acute-care environment ensured the wording and intent of the data gathering reflected accurately in the qualitative questions. The expert panel members agreed to review the questions, relate the proposed questions to the intent of information gathering, and make recommendations on question wording and potential questions.

The panel consisted of a past CEO of the OHA, an ex-CEO of a small Ontario hospital, a previous Ontario acute-care hospital board member, and a previous senior acute-care hospital leader. The first meeting of the expert panel took place in Toronto for easy accessibility to the panel members. The panel received a copy of the dissertation proposal to understand the purpose of the study, the research methodology, and the research questions. Panel members also received a draft of the focus group questions (see Appendix H) in advance for their perusal.

The expert panel meeting began with a discussion on the roles of the hospital board of directors and senior management team in strategic planning for the organization. The panel wanted to ensure inclusion of the role of governance in the strategic planning in the quantitative instrument. Yet, while recognizing that the hospital board of directors

was involved in the strategy formation, much of the preparatory work and implementation of the strategic plan is the responsibility of the senior leadership team. The panel agreed with this understanding. There was further agreement that the board of directors has less involvement with the strategic plan after development other than to receive regular updates.

Active discussion ensued on the role of the LHIN within the strategic plan. The panel received an explanation of the relevance of understanding the level of influence that the LHIN or MOHLTC has upon the development of the hospital strategic plan. The panel discussed that in most hospitals, managing resources is still in its infancy. The funding system has removed accountability for the use of hospital resources from many health-care professions (i.e., physicians). The panel members, speaking as former participants in the acute-care hospital system, remarked that while improvements had occurred in hospital resource use since 2000, ample room exists for improvement in efficiencies. Panel members also raised a concern over the collection of hospital data. Personnel at CIHI collect the majority of hospital data, but the information gathered and rated is meaningful primarily for larger hospitals.

The original draft of seven questions brought to the expert panel meeting resulted in three additional questions for the focus group sessions. Changing some wording helped to bring inclusivity into some of the questions (for example, the addition of *stakeholders* and *consultation* into some questions) or to broaden the question to gather more information about the action or lack of action by senior leadership in the three strategic planning principles (scanning, formation, and implementation). The questions added to the focus group list explored how hospital leaders communicate the strategic plan to other

stakeholders. The wording of the questions was to gain insight into early components of organizational learning plans as part of the implementation process.

The expert panel had an important and lengthy discussion on the difference between measuring organizational performance and monitoring organizational performance. Panel members were unclear regarding the difference between the two words, indicating that further definitions were necessary when discussing this component with the focus groups. The expert panel also discussed the setting of targets and goals for organizational performance, which they felt would be a key point of the study and would provide important data to both hospitals and LHINs on why health-care reforms have not been successful in the past. Changing the wording of two questions would help to clarify the actions of senior leaders. The expert panel believed the question, Do you measure the effectiveness of the strategic plan? would provide the focus groups with the opportunity to answer yes or no to the question. If the focus group answered yes, a follow-up question would ask the senior leaders to provide a specific example, which provided the opportunity to determine whether senior teams are monitoring or measuring, checking boxes, or activating change.

Focus Group Sessions

Prior to beginning the study, the administrators of four hospitals in southern Ontario were approached for consent to participate in focus group sessions for P1 of the study (see Appendix E). The hospitals included one academic center, one community hospital, and two small hospitals. Each of the individuals who signed the Permission to Use Premises form (see Appendix E) were contacted to arrange dates for focus group sessions and all four hospitals responded. Each participating hospital received an

introduction letter to the research (see Appendix F). One hospital administrator suggested utilizing the senior management strategic planning day to observe the process. A date for the following week was secured to meet with the clinical staff at this hospital following the planning session to ask focus group questions; the hospital later canceled this scheduled follow-up.

The types of senior leaders present at the focus group sessions varied. At all four sessions, the CEO of the hospital was present. At two meetings (SMT01, SMT03), the CFO, and chief of staff attended the sessions. Three hospitals included their CNO (SMT01, SMT03, SMT04) at the meetings. Other administrative roles present at various focus group sessions included human resources, operational management, and patient care services. All of the hospitals visited were in various stages of developing a strategic plan for the next three to five years.

Data Collection

At the focus group sessions, all participants at SMT01, SMT02, and SMT04 received the informed consent document and information (see Appendix G) for the research. The organizers of the strategic planning session at SMT03 decided that due to the large number of attendees they would announce the presence of the researcher, and as a form of implied consent, asked if there were any objections to the observation taking place. No participant raised any objection. Using the scripted questions to gain similar information from the focus group sessions, the strategic planning organizers responded to several questions providing further understanding of their strategy planning process. The participants in the focus group sessions gave permission to record the proceedings, and a Panasonic stereo digital recorder was used to capture the sessions. The actual strategic

planning session for SMT03 was not recorded, as the session had too many participants and multiple conversations going on at once. Extensive field notes supplemented by documentation distributed at the session by the organizers provided the basis for data analysis.

Using the questions refined during the expert panel session for the focus group sessions created a foundation for side conversations and observations in the strategic planning session. After a relevant comment by a participant in SMT01, an additional question was added to the list. The participant was discussing the change in the Ontario health-care environment, which provided an opportunity to probe participants on their views on environmental uncertainty and change. The question related to theory on the alignment of strategic plans to environmental change. All focus group sessions and the strategic planning session received the question on environmental uncertainty.

A concern when gathering qualitative data is to obtain sufficient data until reaching saturation (Creswell, 2003b). Four different hospital leadership teams received questions with regard to their strategic planning methodologies. While hospital leadership teams understood the basic tenets of strategic planning, none of the hospital leadership teams fully comprehended the meaning behind the concepts of strategic planning, regardless of whether worked at an academic center or a small hospital. No hospital demonstrated a consistent methodology of moving from the early stages of strategic planning to implementation. Hospital leaders indicated no homogenous method existed to approach strategic planning in the Ontario acute-care environment. Accordingly, no further focus group sessions were organized, as it was not believed that any additional information on specific methodologies would be obtained.

Data Analysis

After completing the focus group sessions, all recorded sessions were downloaded onto a secure external digital drive. The focus group sessions were 32 minutes (SMT02), 39 minutes (SMT04), and 1 hour 3 minutes (SMT01). The observed strategic planning session on 1 day took place in two segments: 9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 4:00 p.m. While listening to the recorded sessions, field notes were reviewed, and further impressions logged and then transcribed using Microsoft Word. The secure external drive contains all documents. Using Panasonic voice-editing software, transcriptions of the focus group sessions were entered word-for-word into a Microsoft Word document. To ensure accuracy, voice sessions were compared against the transcribed documents. The transcripts did not identify any of the participants; as each participant entered the conversation, a new line began in the transcript. Once transcribed, respective hospital leaders received a copy of the documents for their review on the accuracy of the transcript. One participant from SMT02 returned a note clarifying some of the acronyms used during the focus group session.

After the focus group participants had the opportunity to review the transcripts and correct any errors, the coding process began. Coding techniques utilized Spradley's Semantic Relationships (Spradley, 1979) as a methodology to organize the data and examine the data for cause and consequences, interactions, and processes. The following eight sections or sets provided direction on how to organize the data:

1. Strict inclusion: X is a kind of Y (definitions)
2. Cause and effect: X is a result of Y
3. Rationale: X is a reason for doing Y

4. Spatial: X is a part of Y
5. Function: X is used for Y
6. Means-ends: X is a way to do Y
7. Sequence: X is a step in Y
8. Attribution: X is a characteristic of Y

Using a preliminary review of one transcript from SMT02, various subsets resulted within the eight sections for each of the relationship groups. The subsets reflected components of the independent and dependent variables: implementation, measurement, monitoring, performance, planning, scanning, and communication. The determined set and subset groups were developed to look for specific methodologies that indicated strategic planning typologies in the study population.

Coding reliability. To ensure the validity of the assignment of data collected during the focus group sessions and on observation day, it was necessary to ensure that the coding was reliable. Two independent raters agreed to perform the validity check. A member of the expert panel volunteered to be an independent rater. The second rater was a doctoral candidate in health-care administration who works within the Ontario health-care environment. A copy of the SMT02 transcript was forwarded to each rater, along with an e-mail listing the Spradley relationship sets and a list of the subset groups (implementation, measurement, monitoring, performance, planning, scanning, and communication) identified through an examination of the transcript. Each relationship set was assigned a highlighting color for easy identification. The raters were asked to identify the subset that this relationship acknowledged using the tracking device within Microsoft Word (for example, raters identified *staff meetings are a way to give*

information as a means-end relationship set and highlighted it green. The subset of the phrase was communication).

The transcripts were coded in advance of receiving the independent rater's coding to avoid coding bias or influence. Due to a personal emergency, one member of the expert panel was unable to complete the coding exercise. The second independent rater forwarded the completed coding of the transcript. Upon receiving the independent rater's coding, each line of the transcript was reviewed to compare the coding results of the independent rater against the previously coded results.

Over 90% of the previously coded and independent rater codes for both set and subset groups were consistent. A phone conversation with the independent rater involved a review of the discrepancies between the two coding results. There was agreement that much of the transcript was applicable to several data sets and subsets. While a minority of the coding was dissimilar, the independent rater agreed with the previously coded placement of transcript data. Several portions of the transcript were reviewed with the independent rater to discuss what other sets and subsets the data could be assigned to, in addition to the agreed upon primary sets and subsets.

Data analysis. After the independent rater agreed with the previous interpretation of assigned codes to the transcript, transcripts and field notes were downloaded into NVivo 8.0 for evaluation. Use of the qualitative analysis software provided the opportunity to designate specific coding nodes in a variety of levels. The earlier identified Spradley (1979) relationship sets created the tree nodes. The subsets developed from the independent and dependent variables (implementation, measurement, monitoring, performance, planning, scanning, and communication) were listed under each

relationship set. As the transcribed data underwent further analysis, the need for additional tree nodes for hospital size, internal direction, and resource allocation became evident.

Notably, focus group participants used the concepts of performance measurement and performance monitoring interchangeably. Communication linked strongly with strategic implementation. Thus, subset groups decreased from seven categories to four: implementation (implementation and communication), performance (performance, measurement, and monitoring), planning, and scanning. By amalgamating the categories, it became easier to place the data into variable categories without misinterpreting the focus group participants' meaning of context, especially since some terms are substitutable. The coding mix expanded to include two free nodes: environmental change and mission, vision, and values. Both of the concepts relate to strategic planning (Begun & Kaissi, 2004; Kaplan & Norton, 2001; Kumar & Strandholm, 2002), but when discussed by the participants, had loosely connected ties to other relationship set codes. Therefore, separate code categories were created for environmental change and mission, vision, and values.

Upon completing the coding of all transcripts and field notes, it was necessary to collate data subsets into a single category to gain an appreciation of the context of strategic planning components. For example, the subset *implementation* was retrieved from each relationship set and then collated into one file. The same task occurred for the subsets *performance*, *planning*, and *scanning*. By collating the information of each of the subsets from the relationship sets, a broad picture resulted of the three principles of strategic planning and organizational performance. The additional nodes of hospital type,

resource allocation, internal direction, environmental change, and mission, vision, and values completed the perspective of strategic planning by the qualitative study participants.

Phase I Findings

The first three research questions asked about the context and content of strategic planning from the perspective of the senior hospital leader, what hospital leaders view as best practices in strategic planning, and if any differences exist between hospital types as best practices to achieve performance goals. Coding themes in the data analysis provided answers to the research questions. As many of the perspectives and views of the hospital leaders were congruent, the comments are in tables.

Research Question 1

What is the content and context of strategic planning from the perspective of hospital administrators and does strategic planning within this environment emulate other strategic planning methods or theories?

Context of strategic planning. Hambrick and Fredrickson (2005) noted that strategy shows how organizational plans connect with the environment. Organizational leaders determine how they wish to meet challenges and create a strategy to get to those goals. A comment from a participant of SMT01 showed a lack of understanding regarding what strategy is and how strategy is used: “Strategy is about maximizing profit, but we are in a nonprofit organization and so the focus does not work for this environment” (SMT01). The reflections of what strategic planning is as provided by the participants in P1 of the study ranged a “tool or mechanism to achieve mission” (SMT01)

to providing “direction or vision” (SMT02, SMT03). “Strategic is how we see ourselves in the future. How we stay alive and well” (SMT04).

Hambrick and Fredrickson (2005) warned how organizations use internal organization alignments as a part of strategy. Compensation policies, information technology projects, and staff improvement processes should support strategy, but are not necessarily strategic initiatives. The senior hospital leaders made statements that are not consistent with organizational strategy and instead reflect operational management. When probed for strategic goals, hospital leaders provided a variety of operational management choices: becoming “green” in hospital operations, developing staff safety protocols, developing information technology projects, and recruiting and retaining health-care professionals.

Senior hospital leaders from all participant groups discussed the influence that their regional LHIN has upon the health-care environment. All hospital leadership teams showed concern regarding the uncertainty of how the mandate of the LHIN organizations will affect the operations of the hospital, and the ability for hospital leaders to strategically plan. The SMT01 group member noted the senior hospital leaders are “losing the autonomy to decide what we necessarily think may be the best services to provide to our community and it is being driven from a higher plane.” All focus group hospital leaders noted that they do not believe adequate communication on a system-wide vision of health care exists across the province. Although the MOHLTC has outlined expectations of the LHINs, hospital administrators do not believe that the LHINs have an understanding of the mission, vision, and values of the respective hospitals and the

responsibility hospital leaders felt they have toward their communities in providing services.

The LHINs landscape has said you will integrate your strategic plan with our strategic plan, which really isn't addressing our mission so much, and it may even shape or change what our mission needs to be to sort of incorporate a piece of what the LHIN thinks it should be. (SMT01)

I think that the LHINs, like as we go into the next strategic planning process, the LHINs will be an important feature or factor. How do the LHINs see the future to be, that's an expectation that our direction will be somewhat in line with that direction, because that is our overseer of health care. (SMT04)

With changes in the MOHLTC/LHIN funding structures, SMT01 believed that strategic planning required blending business models (revenues and commoditization) and hospital business models (looking after patients). While the MOHLTC officials expect that hospital administrators should create some additional revenue sources (MOHLTC 2006), the administrators did not believe they should be chasing revenues to provide patient care (SMT01, SMT03). The introduction of the LHINs has moved health-care planning to a regional level, where perceived regional needs take a higher priority than perceived individual community needs (MOHLTC, 2006). However, in none of the discussions did the hospital leadership teams bring up examining or altering the way that they perform strategic planning to meet these new environmental changes. Hospital leaders were pursuing previous strategic methodologies even though the MOHLTC has determined that the old way of providing patient care was not working and brought in the reformist LHINs.

Environmental scanning. Organization leaders do not usually conduct comprehensive environmental scanning (Pfeffer & Salancik, 2003). Scanning though is a necessary activity as part of the process of organizational adaptation to the environment (Hambrick, 1982). Health-care leaders' inattention to environmental scanning might cause organizational units or programs to be vulnerable to significant budget cuts or closures (Layman & Bamberg, 2005). Miles and Snow (2003) discussed how organizational leaders' perception of environmental conditions through scanning influenced the decisions on how to deal with these conditions through strategic planning.

Environmental scanning is “probably a foreign concept to most people in hospitals” (SMT01). All hospital senior leadership teams utilized scanning methods that do not require a great deal of resources (see Table 5). One hospital organization had recently undergone a major transformational process in which one campus concentrates primarily on the delivery of mental health and ambulatory services. However, a member of the health-care leaders of this hospital group discussed developing a strategic plan based on the “*presumption* [italics added] that mental health needs are growing” (SMT03), without any apparent objective evidence to support the belief.

When probed on what forms of environmental scanning hospitals undertook, many of the hospital leadership teams ponder the question. Two hospital teams (SMT02, SMT04) spoke about looking for trends using recent hospital admission diagnostic codes as a way of tracking disease progression needs. Although the LHINs have demographic information available for the region they serve and provide epidemiological data to regional hospitals, SMT02 leaders commented on a lack of detailed epidemiological data available for their specific catchment population.

Table 5

Common Themes on Environmental Scanning

No.	Context of strategic planning: Scanning
1	Information sharing with community partners
2	Within organization, do not have individuals with specific task of scanning
3	Environmental scanning is a passive process
4	Unit managers are requested to do a summary of portfolio
5	Use information gathered by outside organizations for local community data

Hospital leaders at all four sites stated that the LHIN leadership expected that strategic planning at the hospital level would incorporate community engagement. Two senior leadership teams stated that they were not sure what the LHIN's definition of community engagement was (SMT01, SMT02). The hospital leaders' frequent refrain that they did not understand LHIN definitions of various terms such as community engagement speaks to the lack of manuals for hospital leaders replicating various documents provided to LHIN leadership by the MOHLTC (Ardal, Butler, & Edwards, 2006, 2007; Ardal, Butler, Edwards, & Lawrie, 2006a, 2006b, 2006c; Ardal et al., 2008). Without documents highlighting expected hospital leadership actions, affecting system health-care strategic planning between LHIN leadership and hospital senior teams will be difficult.

Some hospitals work in community groups or networks (SMT01, SMT04) that are examining how to integrate health-care services; yet hospital leaders noted that the meetings are not a formalized process of environmental scanning. Internal data collected for strategic planning usually comes from staff and physician satisfaction surveys.

Members of another hospital leadership team (SMT04) commented that they look at what programs they feel are affordable when performing environmental scanning or consultations with health-care partners.

Strategy formation. Strategy formation takes information gained from environmental scanning and uses that knowledge to determine how the organization adapts to the environment to meet specific goals (Mintzberg, 1978). Acute-care hospitals in Ontario are required to be responsive not only to patient care needs due to demographic changes but also to the performance expectations of the LHINs. With the transformations in bureaucratic levels of Ontario health care come changes in hospital accountability (MOHLTC, 2006d). “Paradigm for care has changed. Funding is structured differently and changes responsibility. Funding is not provided to look after all patients’ contracted services” (SMT01). The LHINs determine the parameters of hospital care (SMT01, SMT03), including the size and patient acuity level of the hospital. Academic hospitals are the highest acuity level hospital in the province. Community hospitals have some physician specialties and an intensive care unit. General practitioners primarily staff small hospitals and might have one or two physician specialists. Small hospitals do not have intensive care units or supportive care services for patients; consequently, small hospitals have the lowest patient acuity level.

Hospital leaders feel they are being asked to extend their strategic planning beyond their own hospital level to now serve “the system” (SMT01). The LHINs have identified on a regional level strategic priorities supported and integrated at the hospital level (SMT01, SMT04). Hospital leaders expressed feeling pressed by the LHIN administrators to develop integrated care regardless of community desires (see Table 6).

The hospital leaders recognized that community engagement provides information on community expectations, but are unsure how this translates into effective strategic planning (SMT01, SMT03).

And in the LHIN environment, there is an expectation that it is an inclusive process that it not only includes your community, but includes your LHIN identified region. So we are probably working from a base that is not well founded for our own community and now we need to expand that to the region.
(SMT01)

Table 6

Common Themes in Strategic Formation

No.	Context of strategic planning: Formation
1	Do not have specific process to compare <i>Hospital Accountability Agreement</i> responsibilities to outcomes.
2	Utilize scanning processes for business practices
3	Recycle strategic goals if “still relevant”
4	Senior teams are unsure of what LHIN means by integrated care on a system level what this means on an acute care level
5	Frustration in the lack of dissemination of information on system planning from the MOHLTC and LHINs
6	One of the most important tasks of strategic planning is developing efficiencies within the budget

Hospital leaders unevenly used environmental scanning as a vehicle for strategic goal development. “The environment has changed and strategic directions do not reflect

that” (SMT03). SMT03 utilized internal scanning comments from staff to determine strategic initiative development. Initiatives are given priority depending upon how often comments are made by staff members. Upon examining the strategic initiatives, those comments staff least likely mentioned and thus given the lowest priority by hospital leaders, were foundational components to support those initiatives given higher priority. Decision making was dependent upon budget figures (SMT01, SMT04). Hospital administrators try to bring in other organizational members to take ownership of the budget process on a departmental level so that members are cognizant of their resource usage in relation to their funding. The strategic planning process is ongoing as senior hospital leaders examine ways to deliver services (SMT01, SMT04).

Implementation. According to SMT01,

All too often, I think we can create a strategic plan and everybody is really proud of themselves at the end of a lot of work, and then things change and people come and go, and no one is being held to the fire necessarily to achieve those things. So part of the process should have an ongoing demonstration that you have moved the direction of the organization along. I am not sure how you do that. (SMT01)

Hospital leaders outlined various techniques they have used to entice hospital stakeholders into the implementation process (see Table 7). SMT01 created decision making bodies whose members must answer specific questions on behaviors and actions in their areas, make decisions about further area actions, and take accountability for the results of those actions. SMT03 discussed the need to have functional area managers develop their own tactical plans for strategy implementation. SMT04 had continuous improvement quality teams to implement specific action items in the hospital. “It was

presented to the staff and then the strategic goals. . . . [T]hey were shown how the strategic directions developed hospital goals and objectives, and they in turn take it to their departments and develop departmental goals and objectives.”

The practice of using operational tasks or extremely broad statements as strategic goals creates significant difficulties for implementation (Shimizu & Hitt, 2004). SMT03 leaders complained that the strategic directions designed for their hospital are too broad and too many in number to be realistic for implementation. All of the hospital leaders explained that they do a review of the strategic goals annually, but the review was specifically to examine the status of what was determined to be a strategic goal 3 to 5 years prior. No discussion ensued on whether the action items require adjustment for changing environmental conditions.

Table 7

Common Themes in Strategic Implementation

No.	Context of strategic planning: Implementation
1	Lack of engagement by hospital staff and physicians in the strategic plan is of great concern to senior leaders
2	Although a variety of methods are used to disseminate information on the strategic plan, hospital stakeholders do not take ownership of the strategy
3	Hospital leaders are uncertain how to incorporate and implement LHIN strategic goals into the strategic plan designed for the hospital

Organizational performance measurement. When asked about how they use performance measurement to ensure strategic goals are accomplished, hospital leaders looked at each other with concerning glances; they were not quite sure how to respond to

the questions put before them on this topic (see Table 8). Another hospital team (SMT03) created a strategic goal to develop organizational performance measurements. When asked how they measured their organizational performance, hospital leaders turned to various outside agencies' reports for data on how they performed. Hospital leaders additionally used employee and physician satisfaction scores to gauge leadership within the organization. One hospital team (SMT02) did speak about setting a strategic goal around developing LHIN engagement and strategy into the organizational performance.

Table 8

Common Themes in Organizational Performance Measurement

No.	Context of strategic planning: Organization performance measurement
1	Hospital leaders use the terms measurement and monitoring interchangeably
2	None of the senior leadership teams discussed setting targets when describing measuring organizational performance
3	Although hospital leaders mentioned the <i>Hospital Accountability Agreement</i> as a performance requirement, none of the hospital leaders spoke of examining performance for these indicators and making changes to improve organizational performance

Hospital leaders approached organizational performance with different variations. SMT03 looked at performance measurements versus cost. Hospital boards reviewed the LHIN *Hospital Accountability Agreement* and the hospital operating plan to address the *Hospital Accountability Agreement*. The measure used by another hospital group (SMT02) was if senior leaders considered the objective to be met. When probing the hospital leaders on whether they set targets as part of their organizational performance

measurements, they responded that their form of organizational performance fell more towards the “ticky-box” category than setting targets and moving the organization towards those targets.

I know from the interim perspective one of our first steps is, okay, let’s take a look at it. Okay, now we’ve taken a look at it, what are the things that we think we can do better, and then set up something that you can then track, and then take a look at the data that is there, right. I mean, you are pulling it monthly, and taking a look at it. (SMT04)

Hospital leaders were moving toward the development of more formalized organizational performance measurements. SMT01 discussed how they were developing a balance scorecard, but that this initiative is in the infancy stages. A program management mode introduced to senior managers ensured they were aware of their indicators, the expectations in meeting indicators, and the requirements for monitoring and measuring their course of action. SMT04 created continuous quality improvement teams “that have their own indicators they are monitoring throughout.” This group of hospital leaders tracked various clinical indicators to monitor whether they were meeting the needs of their *Hospital Accountability Agreement*.

The results for Research Question 1 emphasized a lack of formal structure to the strategic planning process as practiced by acute-care hospital leaders. Administrators seemed to have little sense of what strategy concept really means and how to put it into practice. The administrators did not perform a comprehensive environmental scanning and tended to use presumptions and assumptions to plan strategic goals. Operational goals served as strategic goals, and many goals were recycled from one strategic plan to

the next, indicating that they were rarely, if ever, achieved. Hospital administrators related that they felt the most important task of strategic planning was developing efficiencies in the hospital budget.

Senior hospital teams were uncertain how to incorporate and implement LHIN strategic goals into the strategic plan designed for the hospital. The leaders did not believe that hospital stakeholders take ownership of the strategy. During focus group sessions, hospital leaders used the terms *measurement* and *monitoring* interchangeably. None of the senior teams participating in the focus group sessions mentioned setting targets or benchmarks when describing organizational performance.

Research Question 2

What do hospital administrators view as best practices in strategic planning (presuming that the planning takes place)?

Process. All the participating hospital leaders believed that the strategy formulation process they utilized was a formalized process. Hospital leaders in SMT03 stated that current strategic planning was crisis management but not proactive strategy. All the hospital leaders examined current strategic goals to see if they should be recycled into the new strategic plan. If the board felt the strategies were still relevant, “we keep going” (SMT04). SMT03 examined the strategic goals of other hospitals of the same size. If those hospitals had strategic goals that SMT03 did not have on their strategic plan, they added those missing goals onto the strategy. As the focus group session ended for SMT01, a hospital leader started to question the appropriateness of the approach:

An organization needs to basically take everything back to ground zero when it starts this. Because in a hospital organization, things change. New MDs come in,

new managers, new directors, new board members. So, while you think that there is a resilient memory of what we did, really there isn't.

Hospital leaders at all four sites stated that LHINs expect strategic planning at the hospital level will incorporate community engagement. Two senior leadership teams stated that they were unsure of the exact the LHIN definition of community engagement (SMT01, SMT02). Hospital administrators used meetings and focus groups with members of the community to gather community perceptions of the hospital mission in meeting health needs. Connecting strategic planning to this form of mission statement was not the norm. A third hospital (SMT03) was undergoing significant organizational transformation. Many senior leaders raised concerns on the lack of mission, vision, and values for the organization in understanding the new role the reformed organization would play in the community. Despite the concerns, administrators proceeded in developing a 3-year strategic plan.

Resource allocation and internal direction. Although hospital administrators are accountable for accessing and supplying the resources necessary to provide patient care, the physicians and nurses utilize those resources. The discussion sessions revealed a conflict between physicians and non-clinician health leaders in the use of hospital resources that was the result of conflicting priorities; hospital administrators were responsible for dollars spent and have no control over patient outcomes, whereas physicians used hospital resources to provide patient care and generate an income for themselves. Physician remuneration and hospital privileges in Ontario acute-care hospitals do not encourage physicians to contemplate resource usage practices and fiscal moderation.

Nonclinician hospital leaders stated that they looked at the resources available and then determined priorities based upon fiscal availability. Hospital leaders solicited ideas for hospital priorities from internal stakeholders and then examined the ideas and accepted or rejected them from further consideration based upon cost (SMT01, SMT02). The name for the committee that operates as the finance committee at SMT01's hospital is the resource allocation committee. Another hospital leader team (SMT03) created a strategic goal to "establish priorities and align the pursuit and allocation of resources with priorities." The authors of this strategic plan believed they require a strategic goal to develop hospital strategic priorities.

In contrast, clinician participants complained in the P1 sessions that hospital senior leaders were planning resource allocation, not the delivery of patient care. "They are not looking at where patients need care" (SMT03). Senior leaders agreed with this perspective to a certain point. Hospital leaders know that physicians want resources available to them that will improve their patients' outcome. The non-clinician leaders reminded physicians that the hospital budgets limited the ability to obtain some resources.

So they come to our organization and they're working away and they're doing what they have been trained to do and they do what they think is going to serve the community. And all of a sudden, that could be changed. So, I am not sure if that is an expectation or a challenge; maybe it's both. An expectation that they need to have a better understanding that they are part of something bigger than their individual practices. (SMT01)

Environmental uncertainty. This topic area was appropriate because the hospital leaders felt they were working within a turbulent environment. Although the participants believed they were working in a turbulent environment, hospital leaders had a great deal of difficulty defining the term. The primary response indicated the new funding initiatives that the government had introduced and the role of the LHINs. “They are tying strategies, are now mandated, and we need to perform, um, the way we are funded is different” (SMT01). When using Emery and Trist’s (1965) definition of a turbulent environment as a dynamic process creating uncertainties for organizations, it was difficult to define the Ontario health-care environment as turbulent. For acute-care hospital leaders, turbulence meant that the leaders must change the way that they manage and strategically plan for hospitals from the norm of the past 30 years, not that the environment itself was turbulent. All of the hospital leaders discussed the need for organizational flexibility, although no deliberations of contingency plans for strategic goals and no discussion of the leadership role in understanding and adjusting to the supposed environmental shift took place. When probed about actions taken when they believed the environment has become more uncertain, the participants made no indication of substantial behavior modifications or actions taken to address the perceived environmental change.

The results for Research Question 2 indicated how hospital leaders recycled strategic goals from plan to plan if the hospital leaders felt the goals were still relevant. Hospital administrators occasionally tied strategic planning to the hospital mission statement. Hospital leaders solicited input from health-care professionals working in the hospital; although cost analysis determined whether to incorporate physicians’ and

nurses' recommendations on clinical strategic goals into the hospital strategic plan, which caused friction between the health-care professional staff and hospital leaders. Although hospital leaders perceived that the health-care environment in Ontario was turbulent, the concern was more likely due to the hospital leaders' uncertainty of how to manage and strategically plan for hospitals in the new LHIN environment.

Research Question 3

What differences in strategic planning and views as best practice to achieve performance exist between types of hospitals (academic, community, or small)?

Leaders in the two small hospitals and one community hospital commented several times that they did not have available staff or staff with particular skill sets to perform much of the preparatory work needed for effective strategic planning. While “we are not as sophisticated as the academic health sciences” (SMT02), the nonacademic centers focused on developing alliances with other health-care partners and sharing information formally and informally on a frequent basis. Small and community hospitals had a limited number of senior leaders who managed a variety of portfolios to carry out the work of the hospital.

Regardless of the hospital size or type, the focus group sessions showed that all of the hospitals in P1 worked under the same assumptions and largely practiced the same methodologies when strategically planning. The only benefit for the academic center was that there are greater human resources to devote to strategic planning tasks as demonstrated at their session. None of the hospital teams that participated in P1 demonstrated that hospital type provides any significant difference in strategic planning practices.

Phase 1 Summary

The purpose of the qualitative portion of the study was to gather the perceptions of senior hospital leaders regarding their understanding of what strategic planning involved. Described in this section were the data collection procedure and an analysis of the data. Three focus group sessions and attendance at a strategic planning session provided the information for analysis. An independent coder verified the coding method of data gathered from the focus group sessions. Transcripts from the focus group sessions and strategic planning session were coded into themes using NVivo 8. The questions that arose from the qualitative phase were incorporated into the development and piloting of the quantitative instrument.

The most notable result of P1 was the finding that none of the hospital types has a formalized strategic planning process that incorporated all of the strategic planning principles of environmental scanning, strategy formation, and implementation. Hospital leaders recycled strategic goals from strategic plan to strategic plan and regularly used presumptions and assumptions about their environment when determining strategic priorities. Hospital senior teams used the terms measurement and monitoring interchangeably when discussing organizational performance. Although hospital leaders perceived the Ontario health-care environment was turbulent, they did not employ techniques to modify or adapt the strategic plan during environmental change.

Quantitative Instrument Development and Piloting

No research on strategic planning in Ontario acute-care hospitals existed. Instruments that researchers have used to examine hospital strategic planning in other countries (Chun-Chang & Feng-Chuan, 2005; Cueille, 2006; Torgovichy et al., 2005)

were not applicable as a single payer funds hospitals in Ontario: the Ontario government. The basis of strategic planning in other industries is how to maintain competitiveness. Hospitals in Ontario do not operate as operators competing for clientele. As no quantitative instruments to measure strategic planning in the Ontario acute-care setting existed, the development of a Likert-type survey was necessary. Construction of the quantitative instrument followed several stages to ensure validity and reliability of the instrument. This section includes subsections on the development of the instrument, expert panel review, and pilot testing of the instrument.

Initial Survey Development

After completing the coding in P1, the research questions and hypotheses were compared against existing theory and the qualitative findings. Four areas of importance became apparent, requiring question development for the survey instrument. The four areas all directly related to the method of strategic planning within the hospital environment and best practices. A significant finding was that the four hospital groups that participated in P1 did not display consistent methodologies to arrive at a strategic plan.

The hospital SMTs in P1 expressed concern with regard to their ability for autonomy when developing a strategic plan. Yet, the regional LHINs require hospitals to incorporate portions of the LHIN strategic goals into the hospital plans as well as community engagement and system integration. None of the hospital leaders participating in P1 was comfortable with the terms (integration, community engagement) or actions required of them (incorporating LHIN strategic goals into their own hospital strategic plan). The hospital administrators reported they have never received formal definitions of

terminology or explanations of how to incorporate community-oriented strategies into the acute-care setting. In terms of resource dependency, more information was necessary on how hospital leaders viewed the influence of regional LHINs when developing their strategic plans.

Two areas of interest relate to environmental change. First, it was interesting to see how hospital strategic goals were primarily operational in nature and how leadership teams carried strategic goals from plan to plan. It is not clear whether hospital leaders really understood the rationale for developing strategic goals and were able to meet their strategic goals on a set schedule. The second area of interest concerned the perceptions of hospital leaders that the Ontario health-care environment was turbulent. Despite common perceptions of turbulence, none of the P1 participants described behaviors that demonstrated modifications or adaptation of the strategic plan to a changing environment. This could be due to hospital leaders' lack of knowledge regarding the purpose of the strategic plan or strategic planning methods. The lack of action indicated either a relative absence of strategic leadership within the acute-care setting that would counter effects of the perceived turbulent environment or that the environment, contrary to their perceptions, was not turbulent.

The fourth area of interest arising from the P1 findings was in association with the retrospective methods employed by hospital leaders when planning strategically. Hospital leaders related that the health-care environment was rapidly changing with the addition of the regional LHINs. The leaders did not discuss any current or proposed changes in organizational design or adopting a new strategic mind-set when approaching patient-care delivery that corresponded with this new bureaucratic level. The absence of concern over

these issues raised questions about whether hospital leaders recognized they might need to adopt a new organizational mind-set, if not a new leadership structure, to adapt to the environmental changes. It is uncertain whether current hospital organizational design fits into the typologies of corporate strategy, competitive strategy, cooperative strategy, or functional strategy and whether current organizational typologies are more beneficial in the new health-care environment.

Based on the research questions, hypotheses, findings in P1, and strategic planning theory, survey questions fit within eight thematic categories: (a) organizational structure, (b) environmental scanning, (c) strategy formation, (d) strategy implementation, (e) resource allocation, (f) resource dependency, (g) organizational performance, and (h) leadership. The first draft of the survey contained 45 questions. Survey Questions 1 and 2 were demographic in nature and sought information about the structure of the strategic plan. The third question asked about the perception of the senior leader on environmental uncertainty. To examine each thematic section adequately, yet keep the survey to a manageable time limit, each section contained five questions. Survey design randomized the placement of the thematic questions. The survey used a five-point Likert-type scale response format as the weighing of answers was consistent and permitted a neutral zone (Neutens & Rubinson, 2002). The response range for Questions 4 to 40 included *never*, *seldom*, *occasionally*, *frequently*, and *always*. The focus of three questions at the end of the survey was on organizational performance and response ranges were specific to the outcome measured.

The survey was loaded on to a Web-based survey platform, Surveymonkey.com. The professional platform allows the encryption of collected survey data for

confidentiality purposes. Web-based survey platform responses are comparable to telephone and postal surveys (Coderre, Mathieu, & St-Laurent, 2004). The expert panel received the first draft of the survey designed on SurveyMonkey for their review and discussion during a scheduled meeting. The researcher provided an electronic copy of the survey to panel members to use when reviewing the questions.

Expert Panel

The expert panel session began with an overview of the findings collected during the qualitative research phase. The panel members posed several questions on the completeness of strategic planning undertaken by hospital senior teams. Following the first meeting, additional discussion took place on the effectiveness of organizational performance measures used or not used by senior hospital leaders. The panel members discussed each of the 46 questions in the draft survey individually to clarify language and ensure that the questions elicited a response compatible to the desired knowledge.

Panel members were emphatic that the wording of questions posed to the senior team would reflect the participation of the governance of the strategic planning process (i.e., the board). Panel members recommended additional descriptions for strategic goals and strategic initiatives or objectives in the definitions page at the beginning of the survey. Two queries added to the beginning of the survey asked for identification of strategic leadership team members and which parties are involved in the development of the strategic plan (governance and management). Those two questions each had a range of options provided. The expert panel continued to express considerable concern that hospital leaders were not measuring organizational performance adequately. Thus, two further questions on performance added to the survey asked whether hospital leaders

were meeting targets and whether the success or inability to meet targets influenced or created change in the organization. The revised survey based on the expert panel recommendations consisted of 49 questions. The number of questions on organizational performance increased from five to seven.

Pilot Testing

The pilot survey in SurveyMonkey.com reflected the results and recommendations from the panel session. The CEO of a community hospital in southern Ontario consented for his senior leadership team of four other individuals and himself to pilot the survey. The CEO received the information by e-mail and circulated it to the senior management team. Originally, the researcher did not provide the survey Web link on the research information sheet. Participants had a great deal of difficulty in accessing the link without a hyperlink in an e-mail. A second e-mail included a hyperlink embedded in the e-mail. The difficulty in accessing the Web site resulted in changes to the introduction letters to ask the administrative assistants to e-mail a request for electronic documentation and Web site links.

The senior leadership team received a copy of the research introduction letter and an evaluation form rating each section and question of the survey. The piloting team assessed the clarity of wording, sufficiency of space to answer questions, and appropriateness of response range. All of the senior hospital leaders responded to the survey. One member of the senior team was vice president of patient care and CNO. The chief of staff was not a senior team member. Only two hospitals included the chief of staff during the P1 data gathering, and the hospital leadership team does not always

include the chief of staff. As the survey did not ask any questions on a clinical level, the lack of physician involvement in the survey pilot did not invalidate any of the questions.

The pilot process resulted in six recommendations. First, contrary to the expert panel's strong recommendations to include the hospital board in strategic planning examination (participants involved in strategic planning), pilot participants advised that a clear separation exists between governance and management in the strategic planning process (who actually did strategic planning). Second, in response to the difficulty that the senior leaders encountered in accessing the Web site, modified participation letters sent to the hospitals asked the administrative assistants to send an e-mail to receive documentation electronically for ease of use and distribution. Most hospital Web sites did not provide an e-mail address to contact the senior management office to send information electronically; consequently, the initial contact with hospital senior leaders involved letters sent using standard mail.

The focus of the third change was the definition page. Pilot participants asked for the term *tactical plan* to be defined. The fourth requested change dealt with additional questions dealing with the kind of strategic plans that existed in acute-care hospitals. A participant asked whether hospitals, despite requirements of accreditation, actually developed a strategic plan. The final two changes targeted response categories. Survey participants noted that many senior hospital leaders were not going to know the answers to some questions, especially the questions that asked about organizational performance. All questions in the survey had a do-not-know category added. The final change addressed comments by participants that the survey participants might wish to add

comments to the question to better explain their choice of answer or add more detail about complex decision making processes.

Pilot Testing Summary

After making changes recommended by the piloting hospital, the final survey designed for P2 of the study included 52 questions. The additional questions examined the status of any strategic plan that existed at the hospital. The questions related to the eight sections based on the independent and dependent variables, as well as theoretical foundations, did not change in number from the expert panel session. The response range for all questions was changed to include a do-not-know selection and included space for individual participant comments.

Quantitative (Phase 2) Study

This section includes a discussion on the collection of data using an online survey, and the analysis of the information gathered. The survey developed for P2 used information gathered from the qualitative phase of the study and current strategic planning theory. By gathering data from different hospitals, the focus of the quantitative phase of the research was on Research Questions 4 and 5 and accepting or rejecting the following hypotheses:

Research Question 4: What is the correlation, if any, between strategic planning and hospital performance in Ontario acute-care hospitals?

Research Question 5: Which type of hospital performs better than others and what, if any, of the three strategic planning principles (environmental scanning, strategy formation, and implementation) are used?

H1₀: Hospital type (academic, community, and small) is not related to use of an identifiable strategic planning framework.

H1: Hospital type (academic, community and small) is related to use of an identifiable strategic planning framework.

H2₀: Hospital type (academic, community, and small) is not related to hospital performance.

H2: Hospital type (academic, community, and small) is related to hospital performance.

H3₀: There is no relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

H3: There is a relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

The study included the use of factor analysis to examine data and determine whether commonalities existed in the survey data. The analysis resulted in the identification of five strategic planning patterns. Due to the form of response scales for the six organizational performance measurements, the use of ANOVA served to determine relationships between the hospital type (academic, community, and small) and the five strategic planning patterns. The MOHLTC and regional LHINs have direct control over the types of patient services provided in hospitals. Thus, it was easier to discern the patient acuity level and geographic location using hospital type. Academic hospitals were in major centers and contained the highest level of patient acuity.

Community hospitals have specialists, usually an intensive care unit, but at a lower level of acuity than academic hospitals. General practitioners primarily staff small hospitals, which usually do not have an intensive care unit and do have a much lower level of patient acuity than academic and community hospitals.

The survey comprised four sections. Eight questions focused on who participated in the development of the strategic plan and the frequency of development or review. Discussion of the data results are in the demographic and strategic planning data section. Thirty-nine questions evolved from thematic components derived from the qualitative findings. The results underwent factor analysis to simplify data into specific constructs. Organizational performance measurements used LHIN and MOHLTC expectations as outlined in the *Hospital Accountability Agreements*. This information underwent ANOVA and Fisher's exact test probability with the factor analysis constructs. The final two questions asked whether hospital senior leaders took steps to meet MOHLTC performance expectations.

Data Collection

The OHA provided a list of hospitals in Ontario within which to distribute the quantitative survey. The list included all hospital sites in Ontario except for those classified as mental health or rehabilitation hospitals. Also removed from the list were the hospital organizations participating in the qualitative and piloting phases of the research. Following the initial elimination process, 130 acute care hospitals remained on the list. A Web search of all remaining hospitals was used to gather addresses and contact information if available. The large majority of hospitals did not have an e-mail address to contact the senior administration team. The lack of e-mail access to senior leadership

teams necessitated the use of standard mail to mail contact letters to hospital organizations.

In the process of obtaining contact information for each hospital organization, it became apparent that several smaller hospitals had integrated their senior management teams. The integration of hospital organizations into service umbrellas further reduced the number of hospital senior leadership teams from 130 acute care organizations to 115 hospital leadership teams. Due to management conflicts with the MOHLTC, three hospitals were under the direction of supervisors, a process by which the MOHLTC removed the hospital board and CEO and placed a government employee at the hospital to provide direction for a certain period. Although each ministry-supervised hospital received a letter to participate, it was uncertain whether the supervisors forwarded the invitation to other members of the senior leadership teams of the respective organizations.

To solicit a response to the letters, envelopes were addressed to the administrative assistants to the hospital CEOs. To facilitate as many senior leaders participating in the survey as possible, the administrative assistants to the hospital CEOs received the research introduction letter and a request to participate. The envelopes included three letters: an introductory letter to the administrative assistant, the research introductory letter, and a support letter from the OHA. A cover letter to the administrative assistant explained the nature of the research, a request to send an e-mail so that all of the Web links and documentation could be forwarded electronically, and a request to send the research documentation to all members of the senior leadership team. As budget preparations for the following fiscal year begin in earnest in the late fall, senior leaders

would be required to devote more time to other duties, and willingness to participate in extraneous activities such as the survey would decrease. A response received from one hospital indicated that the facility was not an acute-care site, but a rehabilitation institute. This reduced the number of hospitals in the final survey population to 114. All administrative assistants to hospital CEOs received a reminder note 3 weeks after the initial introductory mailing. The survey closed 8 weeks after the initial request for participation.

Seventy-seven participant responses were received by the survey closing date, representing 43 hospitals. It is unknown exactly how many senior hospital leaders are in acute-care hospitals in Ontario. Several hospitals had multiple respondents. Some of the research questions asked whether the type of hospital affects the performance of the hospital organization. To differentiate between hospitals for data analysis purposes, academic institutions received a code of 1, community hospitals a code of 2, and small hospitals a code of 3. The research introduction letter contained a preassigned hospital code and survey participants entered the code when beginning the survey. The survey was designed so participants could provide narrative discussion of the questions and their responses if they desired.

Data were downloaded from SurveyMonkey.com in Excel format onto a protected external hard drive. Hospitals with multiple respondents had survey data aggregated. Because the purpose of the study was to examine strategic planning based upon the type of hospital participants represented, and participants were assured of confidentiality, the mean of multiple responses was used to generate a hospital rating for questions. Response means were rounded to the nearest integer.

Data Limitations

The addition of a supportive letter from the OHA was expected to increase the number of participants completing the survey. The relatively low response rate could be due to a number of factors. Officials at several hospitals indicated that the hospital senior team was in the midst of making major revisions to their strategic plan per instructions by their local LHIN and thus did not have time to participate in the survey. The hospital CEOs might have received the initial letters for participation and he or she then determined whether the hospital senior team would participate in the survey. One hospital representative indicated the CEO was away until after the survey closed and the rest of the senior team would not receive the invitation to participate.

A hospital leader indicated that the questions were too difficult to answer. Several participants abandoned the survey halfway through the questions, and it is not clear if the participants were uncertain of the answers and found it difficult to provide reflective thoughts on their organizational processes. Several participant comments in the survey identified the complicated nature of the subject matter, and some participants might have felt the survey was inadequate to capture the complexity of strategic planning in their hospitals. Responses with any missing data were removed from the database.

Analysis and Descriptive Analysis

Demographic Data

Seventy-seven usable responses emerged from the survey, representing 43 hospitals. Various members of the senior leadership team participated, providing a reflection of strategic planning from multiple clinical and operational sectors of the hospital. Fifty percent of the respondents were from senior clinical leaders (CNO, 18%;

chief of staff, 1%; vice president of patient care, 28%; allied health and clinical support, 3%). The other 50% of participants were the CEO (15%), chief financial officer (CFO; 8%), operations (15%), human resources (11%), and information technology (1%).

Staff members of a diverse group of hospitals throughout the province participated in the study (see Table 9). Academic hospitals were in the more metropolitan southern part of the province, and academic hospital administrators replied proportionally in greater numbers than did community and small hospital administrators, which might be because individuals within those hospitals have assigned responsibilities for strategic planning and had greater knowledge and time to complete the survey. The locations of the community and small hospitals were throughout the province and survey responses were geographically diverse, diminishing the potential for overrepresentation of certain geographic locations of the province.

Despite a letter of support from the OHA, response rates were lower than hoped. Although distribution of the survey was withheld until after the summer months, administrators might have been busy catching up with duties after the summer hiatus and not willing to devote time to filling out the survey. Administration teams frequently receive requests to complete surveys and might have decided not to participate due to time restrictions. Senior teams might have felt that their knowledge about their strategic planning process was lacking and did not feel they could adequately contribute to the knowledge-gathering process.

Table 9

Hospital Participation in Survey

Hospital types	<i>N</i>	<i>n</i>	% of <i>N</i>
All acute-care hospitals	114	43	38
Academic	11	7	58
Community	59	18	33
Small	63	18	34

Strategic Planning Participation and Frequency

The study involved the use of several questions to determine who participated in developing the strategic plan, frequency of strategic planning activities, and duration of the strategic plan. Survey participants related that only the hospital board (20%); a combination of board and senior team members (45%); or senior team leaders, board members, and community partners (35%) might perform strategic planning. In several hospitals, only the board of directors participated in developing the strategic plan. Even more surprising, all three types of hospitals are represented in the only board of directors category. Hospital boards are usually composed of individuals not in a health-care role who have limited knowledge in hospital functions and clinical activities. Without this background knowledge, it would be difficult for board members to identify critical patient needs and generate a useful plan.

The hospital senior team leaders who participated in strategic planning varied (see Figure 2). The hospital CEO was a part of all strategic planning activities. Well represented in strategy development was the CFO and clinical team members (Chief of

Staff, Chief Nursing Officer, VP of Patient Care). Other individuals participating in strategic planning included individuals from human resources, leaders from medicine, nursing, and allied health, and information technology and information systems. Because hospital administrators used a variety of expertise when developing the strategic plan, it would be expected to find in the strategic initiatives goals that encompass a variety of corporate and clinical needs. Because hospital leaders stated that they based much of their strategic plan on operational management, the lack of involvement of the chief operations officer (COO) is concerning. The lack of active involvement by the COO indicates a knowledge gap that limits the ability of hospital leaders to execute the strategic plan through operations.

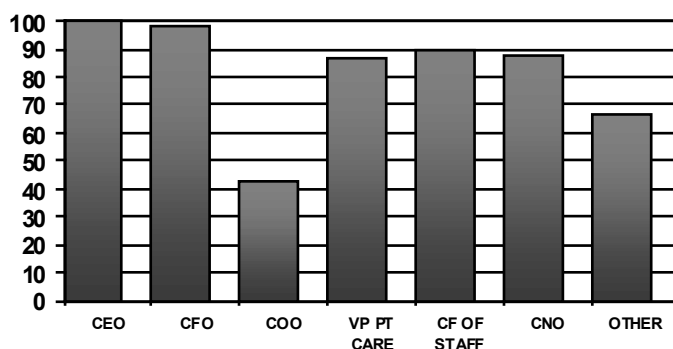


Figure 2. A percentage of hospital senior leaders participating in strategic planning.

The frequency of hospital leaders undertaking strategic planning activities and the age of strategic plans varied. Survey participants noted that strategic planning took place from every one to five years (see Figure 2). Seven percent of participants did not know how often the strategic planning process occurred. For those hospitals that created a strategic plan on a yearly or biannual basis, it was uncertain if goals are yearly determined targets instead of being strategic or long-term goals. The lack of knowledge by senior leaders regarding how frequently a strategic plan was created for their

organization leads to a question regarding the relevance and importance of the strategic plan in the organizations. By hospital type, academic hospital administrators created a strategic plan every three years on average, and community and small hospital leaders created strategic plans every two years.

When asked how long the current strategic plan has existed in their organization, 25% of respondents stated less than one year, 15% claimed their strategic plan was a year old, and 17% said the plan was two years old. The strategic plan was three years old in 18% of hospitals, four years old in 17%, and between five and seven years old in 8% of hospitals. With the amount of change that has occurred in hospital acute-care environment over the past two years, a concern existed regarding whether the organizations with a strategic plan greater than three years old would have any goals with relevancy to the current expectations of the regional LHINs. On average, academic and community hospitals developed strategic plans within the past year. Small hospital strategic plans were on average three years old. All three hospital types were represented in responses by leaders who stated that their strategic plan was four years or older.

When questioned about the frequency of strategic plan review by the leadership team, 17% of hospital leaders stated they reviewed the plan every two years, 58% reviewed the plan every year, and 3% of the hospital teams reviewed the plan every six months. Seventeen percent reviewed the plan every three to four months, and 9% of hospital administrators did not know how often a strategic plan review takes place for their hospital. On average, all three hospital types were represented in the once per year review category. Participants stated consistently that the strategic planning review process was an informal process and was inconsistent. Several participants stated that the

focus of the strategic planning review was on capital and corporate initiatives rather than the full complement of activities that the hospital performs.

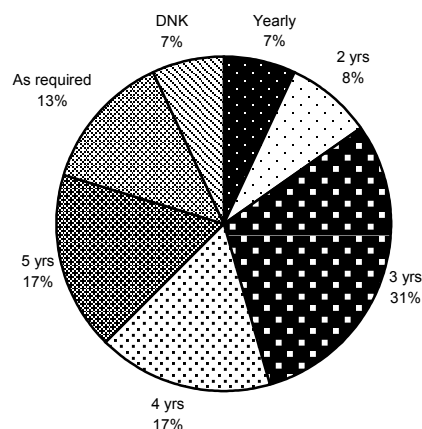


Figure 3. Frequency of developing a new strategic plan.

In terms of specific steps that hospital leaders used when reviewing the strategic plan, the administrators placed a lesser degree of importance on examining the external (71%) and internal (75%) environments and greater emphasis on reviewing strategic goals (88%), and strategic initiatives (85%). Almost all the hospital leaders (90%) reviewed the appropriateness of goals and 86% reviewed organizational measurements and targets.

When examining the data by hospital type, all academic hospitals leaders reviewed strategic initiatives, strategic goals, and appropriateness of goals. Of the seven academic hospitals whose staff participated in the study, all but one hospital reviewed external and internal environmental data, and two hospitals did not review measurements and targets. Community hospitals were similar in undertaking a comprehensive strategic planning review: all community hospitals reviewed strategic goals, measurements and

targets, and appropriateness of goals. Another hospital did not review external and internal environmental scanning data, and another hospital did not review strategic initiatives. Small hospitals were less successful in completing comprehensive strategic planning reviews. Only 65% of small hospitals reviewed external environmental scanning data and 71% reviewed internal scanning data. A slightly higher number of hospitals reviewed strategic initiatives (76%), strategic goals (82%), and the appropriateness of those goals (82%). Most of the small hospitals reviewed measurements and targets (88%).

The beginning of the survey included a definition of environmental turbulence in the terminology definitions. Hospital leaders overwhelmingly believed that the Ontario health-care environment was at a high or a very high level of turbulence. Comments from participants indicated that the economic uncertainty and new funding structure contributed to the turbulence. Other participants noted that the degree of disconnect between the ministry, LHINs, and hospital administrators was at a dangerous level. One participant stated that if the ministry moved to regionalize or rationalize hospital services, the level of turbulence would increase from high to very high levels.

The distribution of responses to the question was interesting in both the hospital type and administrative position within the hospital. Data analysis was used to determine when ranking the level of environmental turbulence, what were the percentages of hospital administrators from various hospital types (academic, community, and small). For those administrators who answered environmental turbulence was very high, 33% were from small hospitals, 50% were from community hospitals, and 17% were from academic hospitals (see Table 6). Community hospital leaders, followed by small hospital

leaders, were more likely to perceive that the environment was turbulent. The majority of senior leaders who felt that turbulence is very high are clinical administrators (vice president of patient care, CNO) at 44%, followed by CEOs at 27% (see Table 7). Vice president of patient care rates might be high because the MOHLTC is pressing health-care leaders to think of new cost-effective methods to deliver patient care. This category contains only three other leadership positions: human resources (17%), communications (6%), and foundation (6%).

Table 10

Respondent Percentage of Environmental Turbulence Perception by Hospital Type

Hospital type	Very high	High	Moderate
Academic	17	14	50
Community	50	57	42
Small	33	29	8

Administrators from community hospitals were the majority of respondents at the high turbulence level (57%). Small hospitals represented 29% of respondents and academic hospitals represented 14% (see Table 10). Of the hospital leaders who judged the health-care environment to be at a high level, the gross majority came again from the clinical leadership positions (CNO, chief of staff, vice president of patient care, clinical support) at 57% (see Table 7). The CFO followed at a distant 14%, and the CEO followed at 7%. Other health-care leaders were at much lower levels: vice president support (3%), chief information officer (4%), COO (7%), human resources (4%), and communications (4%).

In the moderate level of turbulence (see Table 6), the majority of respondents were small hospitals (50%), followed by community hospitals (42%) and academic hospitals (8%). While clinical participants led in the very high and high turbulence levels, small hospital CEOs led in the moderate level (34%), followed by human resources (25%; see Table 11). Clinical leaders (CNO, vice president of patient care) felt the moderate level was most appropriate at 17%. Other participants who felt the moderate level reflected the current turbulence level of Ontario health care were COOs, CFOs, and communications, each with 8%.

Table 11

Respondent Percentage of Environmental Turbulence Perception by Position

Position	Very high	High	Moderate
Clinical leaders	44	57	17
CEOs	27	7	34
Other nonclinical leaders	29	36	49

The results were interesting because the CEOs of small hospitals felt that the health-care environment was only at a moderate level of turbulence. It might be that the hospital administrators were in closer contact with the professional medical staff and community members, giving them greater assurance of events taking place within their patient service area; thus, the moderate level would be expected. Due to the larger acutely ill geriatric population, it was not surprising that hospital clinical leaders were the greatest respondents in the high and very high turbulence levels. The administrators face greater challenges in working with other overwhelmed health agencies to provide care for complex patients.

Quantitative Data Analysis

The research intent was to use the survey data to determine if hospital administrators used certain patterns when strategic planning and if the strategic planning was successful in meeting specific goals set by the LHINs and MOHLTC. To obtain this information, the data underwent factor analysis and ANOVA. SPSS version 16 software performs numerous applications to achieve the entire analytical process and was used in the study. Most survey participants completed the survey questions providing descriptive data ($n = 77$). When segmenting out survey questions for the factor analysis, participants' results were less consistent. The inconsistency might be due to participants' unfamiliarity with the strategic planning process in their organization. From the raw survey data, of all the cases processed, 52 valid cases were accepted.

Factor Analysis

The aim of factor analysis is to simplify a large amount of intercorrelated measures to a smaller number of representative factors (R. Ho, 2006). Factor analysis indicates that all variables have some form of correlation (R. Ho). The factor analysis used in the current research study involved an attempt to reduce the identified subject areas identified in the qualitative phase into specific factors and then searching for a correlation with MOHLTC-determined organizational performance measures.

The use of principle component factor extraction with Varimax normalization rotation techniques resulted in clusters of loadings that identified orthogonal factors for hierarchical analysis. Most questions moderately correlated with each other, and none showed exceptionally high or exceptionally low correlations. The histogram of residuals approximated a normal distribution. Use of a scree test identified a break point

(flattening) between five and six factors; therefore, five factors were significant for the data analysis. Cronbach's alpha measured internal consistency. A value of 0.7 or above indicates internal consistency (R. Ho, 2006; Spicer, 2005). Factor 1 met this criterion (see Table 12). As the alphas not acceptable, the strategic patterns are weak, and this might have contributed to the lack of significant relationships in organizational performance. The weakness of the strategic patterns also might indicate that strategic planning used by hospital administrators did not provide much value in the exercise.

Table 12

Factor Analysis of Strategic Planning Survey

Factor	Subscale items	Cronbach's α
1. LHIN focused	13, 16, 17, 18, 19, 28, 29, 31, 40, 42, 45	.746
2. Regional focused	11, 20, 21, 23, 25, 35, 37, 38, 46, 47	.656
3. Independent	15, 22, 27, 30, 33, 34	.587
4. Performance based	26, 36, 39, 41, 43, 44	.669
5. Team based	9, 10, 12, 14, 24, 32	.603

In interpreting the factors, the size of the factor loadings was important to assess representativeness (Spicer, 2005). A general rule of thumb indicates that a factor loading greater than ± 0.33 meets the minimal level of practical significance (R. Ho, 2006). All the factor loadings for the five factors had loadings greater than or equal to 0.3 (see Appendix L). Factors 1, 2, and 3 had the most clear-cut separation of questions into the respective factors and captured approximately 60% of the variation in the survey data. Upon examination of the five factor loadings, Factors 4 and 5 indicated different strategic

planning patterns than the first three factors. Thus, Factors 4 and 5 are part of the final grouping of strategic patterns.

Several variables loaded on multiple factors. The variable loading weight provided an indication of the strength of that variable to the respective factor. An examination of the wording of the cross-loaded variable took place for face validity to ensure it was the most conceptually representative of the factor (R. Ho, 2006). The variables with the highest loading weight and face validity remained attached to that factor; factors with a lower loading weight of that variable had the variable removed from the respective subscale.

Factor Analysis Findings

Five distinct thematic strategic planning patterns emerged from the analysis: LHIN focused, regional focused, independent, performance based, and team based. Squared multiple correlations (R^2) were used to examine commonalities for each relationship in the model. The R^2 values for these factors indicated that the model fit is good (R. Ho, 2006). Although some similarities occurred between factors, each had specific differences in the priorities placed upon funders, internal stakeholders, and relationships with other health-care providers. A description of each of the thematic factor's characteristics follows. Appendix M has a listing of questions grouped by factor.

Factor 1: LHIN focused. The organizational structure for this strategic planning pattern was a blend of competitive and financial (Topping & Hernandez, 1991); the hospital leaders who practiced LHIN-focused strategic planning were concerned with differentiating their hospital services from other regional hospital services and frequently used allocation of financial resources as the driver of the strategic plan. Hospital leaders

used the regional LHIN strategic goals when considering the strategic directions for their hospital plan, even though they felt that LHIN goals were not appropriate for acute-care institutions. The leaders perceived that outside funding bodies had a great deal of influence in the direction of the hospital strategic plan. The hospital administrators felt that for the most part, professional staff utilized hospital resources in accordance with the hospital strategic plan.

The leaders believed that the LHIN occasionally assisted with resources to build core competencies to meet organizational strategic goals, but assistance modalities are not well developed. Hospital leaders frequently increased their environmental scanning activities if they perceived that the health-care environment became more turbulent, but the scanning activities were not formalized routines. The hospital leaders occasionally created alternative initiatives to meet strategic goals, but felt the alternatives were tactical and not strategic in nature. Most of the hospitals limited themselves to 10 strategic initiatives although most leaders also admitted there were more initiatives than can be successfully completed during the lifespan of the strategic plan.

As the administrators noted, the MOHLTC and LHIN leadership had not solidified, nor communicated effectively, the provincial and regional strategic plan. The LHIN was a large influence on hospital strategic direction, and because hospital leaders' own strategic planning process was informal, there was a danger that LHIN initiated changes or that community changes would go unnoticed by the hospital leaders until a crisis point erupts. Because the focus of influence was the LHIN, a consideration of professional medical staff needs in the strategic plan was lacking, which could have ramifications on professional staff buy-in to the strategic plan as well as to retention and

recruitment initiatives. Any alternatives that existed for adapting the strategic plan to changing environmental conditions were not strategic in nature, so the ability of hospital leaders to meet strategic goals designed to improve organizational behaviors was significantly less. Because the hospital leaders look to the LHIN for an indication of strategic behavior, the hospital leaders have not placed any emphasis on determining their own organizational performance measurements.

Factor 2: Regional focused. The organizational structure of this strategic planning pattern was cooperative (Topping & Hernandez, 1991). Hospital leaders believed that to utilize scarce resources better, patients should seek some general acute-care services from other hospitals in the region. Although this group of hospital leaders considered physician determination of clinical needs, this consideration was on an operational level and was not strategic. A high priority for this group of administrators was developing the hospital strategic plan in alignment with the LHIN regional vision. The hospital administrators used the LHIN expectations of hospital performance to develop the strategy.

Some degree of overlap and carryover of goals and initiatives occurred from strategic plan to strategic plan. When significant changes occurred in the health-care environment, hospital administrators frequently changed the goal instead of altering the strategic plan, and hospital administrators made changes to the strategic plan somewhat unwillingly. If alternatives or changes were available to meet strategic goals, usually the changes were tactical and not strategic. Leaders in the hospitals maintained an organizational culture that promoted the recognition of staff who contributed ideas on how to meet strategic goals and recognized they could increase their efforts to promote such a culture.

This group of administrators had worked hard to incorporate the LHIN mantra of community involvement and regional health-care planning. Because professional medical staff needs received consideration in an operational and not strategic fashion, there was a risk of lack of buy-in by staff into the developed strategic plan. As the health-care leaders looked at patient services to be planned on a regional level, little scanning took place on an internal or external level, which had placed the organization at risk of not being able to recognize immediate community needs and advocating for those services to the LHIN. The hospital leaders used LHIN performance expectations to develop strategy, but did not mention creating performance measurements as a routine activity.

Factor 3: Independent. This strategic planning pattern did not exhibit any of Topping and Hernandez's (1991) organizational structures or display any influence by either hospital professional staff or outside funding bodies. The actions of the senior team were the focus of the behavior of this group of leaders. The leaders looked at the competencies and skills of internal stakeholders, especially of physicians, but did not scan the external environment for information on community needs. An individual on staff had evaluation and measurement expertise. Instead of an individual assigned to inform others of the hospital strategic goals and initiatives, the senior team felt this is the responsibility of all leaders within the hospital organization. There usually was no formal plan associated with the distribution of information on the strategic plan.

The leaders ensured that organizational performance systems existed for financial and clinical key performance indicators (KPIs). Leaders of small hospitals felt they need more assistance to perform this activity. Each functional area and patient unit of the

hospital had developed its own tactical plan designed to meet organizational strategic goals. The action was new for most hospitals and is still in development.

The leaders focused internally on what they felt are best practices. Little recognition of the LHIN or professional medical staff took place when determining the strategic plan. The leaders placed no emphasis on regional relationships or scanning of the external environment. This placed the administrators at risk of being unable to respond to environmental changes. The hospital leaders developed financial and clinical KPIs based on the hospital leaders' ideations, not the LHINs. The introduction of functional area and patient unit tactical plans was a movement toward greater participation by hospital stakeholders in the achievement of the strategic plan, but minimal involvement.

Factor 4: Performance based. The strategic planning pattern displayed a financial organizational structure (Topping & Hernandez, 1991). The concern of the hospital leaders was to examine how each functional area created strategic initiatives to support the organizational strategies. The leaders who practiced this philosophy felt that this mind-set was new in the Ontario health-care environment. To maximize resources, the hospital leaders referred to inventories of patient services of other hospitals or health providers before determining their own hospital's strategic goals. The leaders relied upon external sources to provide environmental scanning information.

Performance-based hospital leaders had identified key clinical performance indicators that tied into the LHIN hospital expectations. However, the leaders did not tie the expected performance indicators as set by the LHIN into the strategic plan; the administrators saw the *Hospital Accountability Agreement* as separate from hospital

strategy. To meet strategic goals, hospital leaders set targets and measured movement toward the targets. An individual on staff was responsible for monitoring whether objectives identified are met in the strategic plan.

The hospital leaders responded to the new LHIN expectations of acute-care accountability for both financial expenditures and hospital performance. The fact that the administrators separated the hospital strategy from the *Hospital Accountability Agreement* is concerning, as without building the performance expectations into the overall strategic plan meant a reduced chance of meeting any targets. A risk that separating the two sets of goals would be counterproductive to *Hospital Accountability Agreement* expectations also existed. The ability to meet performance expectations was in jeopardy without soliciting the input and feedback from hospital stakeholders.

Factor 5: Team focused. The focus of the hospital administrators was on the people within the organization. The organizational structure of the hospital group was corporate (Topping & Hernandez, 1991); because of the scope of practice that their physicians maintain, the leaders consulted with other regional health providers to decide which facility would provide various patient services. Frontline physicians and nurses frequently participated on a high level in the strategic planning process. Functional area and patient unit managers were part of the strategic planning development group. In this pattern, creating teams or task forces of physicians, nurses, and community partners when creating strategic goals was important to the hospital leaders.

In the hospitals, an individual is responsible for creating reports on a regular basis about population health in the community. The hospitals frequently drew upon external information for internal report generation. Depending upon the availability of resources,

the hospital leaders frequently provide access to education programs to help employees to gain specific skills and competencies that meet the organizational strategic goals.

The administrators work to have the maximal input from hospital stakeholders to gain buy-in on the strategic plan. The focal point is on internal and community stakeholders, including other regional health providers. The administrators give little attention to the expectations or influence of the LHIN. In this pattern, the focus of scanning and formation activities of strategic planning is on gathering information from internal stakeholders. The strategic planning process includes no implementation or organizational performance components. Thus, despite all the work in gaining input into the strategic plan, the administrators put little effort into making the plan actually happen.

Phase 2 Hypothesis Tests

The three hypotheses questioned how hospital size, patient acuity, and geographic location related to identifiable strategic planning frameworks and hospital performance and whether any relationship existed between hospital performance and an identifiable strategic planning method. The last two research questions asked what the correlation was, if any, between strategic planning and hospital performance in Ontario acute-care hospitals and if any hospitals performed better than others using strategic planning techniques. Because the MOHLTC and regional LHINs determine the level of patient acuity and what services the hospitals provide, it was easier to distinguish how hospitals differentiate in strategic planning based on whether they are academic, community, or small organizations.

Hypothesis 1

H1₀: Hospital type (academic, community, and small) is not related to use of an identifiable strategic planning framework.

H1: Hospital type (academic, community, and small) is related to use of an identifiable strategic planning framework.

The study included the use of a one-way ANOVA to test for preference differences among the hospital types (academic, community, and small) and the five strategic planning patterns. Each strategic planning pattern contains tables outlining condition means, standard deviations, and sample sizes, as well as the complete ANOVA source table. All statistical tests had an alpha level of .05. Only one significant result was discovered in the independent strategic planning pattern.

Factor 1: LHIN focused. A one-way between-subjects ANOVA was conducted to compare the relationship between hospital type and LHIN-focused strategic planning pattern. No significant effect of hospital type on LHIN-focused strategic planning occurred at the $p < .05$ level for the three conditions ($F[2,39] = .48, p = .62$; see Tables 13 and 14).

Table 13

Descriptive of Hospital Type and LHIN Focused Strategic Planning Pattern

Hospital type	<i>N</i>	Mean	<i>SD</i>
Academic	7	-.02	.51
Community	17	-.16	.84
Small	18	.16	1.23
Total	42	.00	.98

Table 14

Analysis of Variance for LHIN Focused Strategic Planning Pattern

	SS	df	MS	F	p
Between groups	.95	2	.47	.48	.62
Within groups	38.54	39	.99		
Total	39.48	41			

Factor 2: Regional focused. A one-way between-subjects ANOVA was conducted to compare the relationship between hospital type and the regional-focused strategic planning pattern. No significant effect of hospital type on regional-focused strategic planning existed at the $p < .05$ level for the three conditions ($F[2,39] = .34, p = .71$; see Tables 15 and 16).

Table 15

Descriptive of Hospital Type and Regional Focused Strategic Planning Pattern

Hospital type	N	Mean	SD
Academic	7	.24	.63
Community	17	.04	.95
Small	18	-.13	1.23
Total	42	.00	1.03

Table 16

Analysis of Variance for Regional Focused Strategic Planning Pattern

	SS	df	MS	F	p
Between groups	.75	2	.38	.34	.71
Within groups	42.98	39	1.10		
Total	43.73	41			

Factor 3: Independent. A one-way between-subjects ANOVA was conducted to compare the relationship between hospital type and independent strategic planning pattern. A marginally significant result existed at the $p < .05$ level for the three hospital types ($F[2,39] = 3.42, p = 0.04$; see Tables 17 and 18). Tukey post-hoc comparisons of the three hospital types indicated that in comparison with academic hospitals ($M = .64, p = .05$), small hospitals ($M = -.45$) had an inverse relationship with the independent planning pattern. Comparisons between the community hospitals ($M = .21$) and the other two groups were not statistically significant.

Table 17

Descriptive of Hospital Type and Independent Strategic Planning Pattern

Hospital type	N	Mean	SD
Academic	7	.65	.45
Community	17	.21	.69
Small	18	-.45	1.39
Total	42	.00	1.09

Table 18

Analysis of Variance for Independent Strategic Planning Pattern

	SS	df	MS	F	p
Between groups	7.28	2	3.64	3.42	.04
Within groups	41.56	39	1.07		
Total	48.84	41			

The inverse relationship between leaders of small hospital and their counterparts in larger organizations is likely due to availability of resources. Contrary to their academic and community hospital associates, administrators of small hospitals were more likely to state that they did not have individuals assigned to inform others of the strategic plan of the hospital or have individuals with evaluation and measurement expertise.

Factor 4: Performance based. The use of a one-way between-subjects ANOVA helped to compare the relationship between hospital type and performance-based strategic planning pattern. No significant effect of hospital type on performance-based strategic planning existed at the $p < .05$ level for the three conditions ($F[2,39] = .51, p = .60$; see Tables 19 and 20).

Table 19

Descriptive of Hospital Type and Performance Based Strategic Planning Pattern

Hospital type	<i>N</i>	Mean	<i>SD</i>
Academic	7	.35	.95
Community	17	-.01	1.06
Small	18	-.12	1.09
Total	42	.00	1.05

Table 20

Analysis of Variance for Performance-Based Strategic Planning Pattern

	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Between groups	1.15	2	.57	.51	.60
Within groups	43.77	39	1.12		
Total	44.92	41			

Factor 5: Team based. The use of a one-way between-subjects ANOVA helped to compare the relationship between hospital type and team-based strategic planning pattern. None of the differences for this factor grouping was statistically significant at the $p < .05$ level for the three conditions ($F[2,39] = .90, p = .41$; see Tables 21 and 22).

Table 21

Descriptive of Hospital Type and Team Based Strategic Planning Pattern

Hospital type	<i>N</i>	Mean	<i>SD</i>
Academic	7	0.57	1.21
Community	17	0.70	1.46
Small	18	-.29	1.54
Total	42	.00	1.46

Table 22

Analysis of Variance for Team-Based Strategic Planning Pattern

	SS	<i>df</i>	MS	<i>F</i>	<i>p</i>
Between groups	3.86	2	1.93	.90	.41
Within groups	83.56	39	2.14		
Total	87.42	41			

In summary, only Factor 3, the independent strategic planning pattern, showed marginal statistical significance for small hospitals, and the result was due to the unavailability of resources to this hospital type. Administrators for small hospitals were less likely to have financial and clinical measurements or to have individuals assigned to evaluate and measure the organizational performance. As the result was marginal and inversely related due to lack of resources, the variations were not enough to provide a clear identifiable strategic planning framework between hospital types. Thus, the null hypothesis was not rejected. Hospital type does not appear related to use of an identifiable strategic planning framework.

Hypothesis 2

H2₀: Hospital type (academic, community, and small) is not related to hospital performance.

H2: Hospital type (academic, community, and small) is related to hospital performance.

All hospital boards sign the *Hospital Accountability Agreement* for their organization and were expected to meet the six organizational performance measures criteria associated with their hospital type. The six organizational performance criteria were percentage of full-time nurses, financial current ratio, and readmission rates for myocardial infarction, chronic bronchitis, chronic heart failure, and diabetes. Each of the organizational performance measures was examined for a relationship with the three hospital types. For the hospital organizations represented by several administrators, the results were aggregated and the mean used to represent findings from those hospitals, which brought the number of hospitals used in the analysis to 41. Do-not-know responses were classified as missing data and were removed from the data sets. All statistical tests had an alpha level of .05.

OPI: Percentage of full-time nurses. The *Hospital Accountability Agreement* required hospital administrators to have more than 70% of their nursing staff as full-time equivalents. Survey responses noted that 48% of hospital administrators stated that between 71 and 80% of their nursing staff was full-time. Less than 2% of hospital administrators stated that they did not know how many nurses were full-time at their organization; as a consequence, removing these results from the data did not significantly reduce the ability to ascertain whether differences existed between hospitals. Almost half

of the hospitals had met the required target. Not attaining the desired 70% could be due to lack of human resources available within their area or budget restrictions, and full-time nursing positions were reduced to meet budget constraints. Because the results of OP1 were normally distributed, a between-subjects ANOVA was used and treated the variable as measured on an interval scale. No statistical significance existed between hospitals ($F[2,41] = .93, p = .40$; see Tables 23 and 24).

Table 23

Descriptive of Hospital Type and Percentage of Full Time Nursing Staff

Hospital type	Mean	SD	N
Academic	3.87	.69	7
Community	3.69	.60	16
Small	3.44	.85	18
Total	3.61	.74	41

Table 24

Tests of Between-Subject Effects on Hospital Type and Percentage of Full Time Nurses

	Type III SS	df	MS	F	p
Corrected model	1.02 ^a	2	.51	.93	.40
Intercept	462.84	1	462.84	848.05	.00
Group	1.02	2	.51	.93	.40
Error	20.74	38	.55		
Total	556.00	41			
Corrected total	21.76	40			

Note. ^a R-squared = .05 (adjusted R-squared = -.003).

OP2: Current ratio. The current ratio measured the financial liquidity as an indicator of financial health. Lower values indicate a limited ability to make short-term debt payments, while high values indicate resources that have an opportunity for investment. The provincial government promotes greater fiscal responsibility for hospital to ensure that the hospitals do not move into insolvency and spend any excess resources. The target for this performance goal is a corridor of 0.8 to $2.0 \pm 10\%$. The measurement of organizational current ratio measurements did not show any difference between hospital types (see Tables 25 and 26). Due to some data cells having less than five responses and the small sample size, two-sided Fisher's exact test was used instead of chi square. Just over one fourth of the participants did not know the status of their hospital current ratio (27.9%) and the responses were considered missing data. Reduced counts required the comparison of counts (OP2 by hospital type) to be collapsed into two categories. No differences existed between the three hospital types, and as a result, no statistical significance exists ($p = .39$).

Table 25

Hospital Type–Hospital Current Ratio Cross Tabulation

Hospital type	Hospital current ratio		Total
	1.5 or less	More than 1.5	
Academic	5	1	6
Community	11	3	14
Small	6	5	11
Total	22	9	31

Table 26

Fisher's Exact Test of Hospital Type and Current Ratio

	Value	df	p (two-sided)	Exact p (two-sided)
Pearson chi square	2.28	2	.32	.39
Likelihood ratio	2.24	2	.33	.39
Fisher's exact test	2.08			.39
N of valid cases	31			

OP3: Readmission rates for myocardial infarction. The majority of the respondent results for this question were *do not know* (56.9%). Because this response was considered missing data, all the results were removed from the two-sided Fisher's exact test cross tabulation, which reduced the response data set measurably, and there was an extremely small *no* response rate (5.9%). Once broken into hospital type, no significant statistical result existed ($p = .18$; see Tables 27 and 28).

Table 27

Hospital Type–Myocardial Infarction Cross Tabulation

Hospital type	Hospital current ratio		
	1.5 or less	More than 1.5	Total
Academic	5	1	6
Community	11	3	14
Small	6	5	11
Total	22	9	31

Table 28

Fisher's Exact Test of Hospital Type and Myocardial Infarction

	Value	df	p (two-sided)	Exact p (two-sided)
Pearson chi square	4.35	2	.11	.15
Likelihood ratio	5.33	2	.07	.15
Fisher's exact test	3.65			.18
N of valid cases	20			

The information extracted from the data as discussed under H_{10} underlined the inability of hospital administrators to create measurement and evaluation tools to examine their organization's performance.

OP4: Readmission rates for chronic bronchitis. Only one third of the respondents for this question answered *yes* or *no* (66.7% answered *do not know*). Because the do-not-know response was considered missing data, all of these results were removed from the two-sided Fisher's exact test cross tabulation, which reduced the response data set measurably. Once broken into hospital type, no significant statistical result existed ($p = .52$; see Tables 29 and 30). The overwhelming do-not-know response rates highlight the challenges that hospital leaders had in determining whether they were meeting LHIN and MOHLTC expectations in organizational performance. The lack of knowledge on patient outcomes for care received at their hospitals emphasized the lack of clinical knowledge at the senior management level. If an aim of the hospital senior teams was to reduce lengths of stay and emergency room treatments, this information is critical in determining strategic directions as outlined by the LHIN.

Table 29

Hospital Type–Chronic Bronchitis Cross Tabulation

Hospital type	Chronic bronchitis		Total
	Yes	No	
Academic	2	0	2
Community	5	3	8
Small	4	0	4
Total	11	3	14

Table 30

Fisher's Exact Test of Hospital Type and Chronic Bronchitis

	Value	df	p (two-sided)	Exact p (two-sided)
Pearson chi square	2.87	2	.24	.36
Likelihood ratio	3.96	2	.14	.23
Fisher's exact test	2.11			.52
N of valid cases	14			

OP5: Readmission rates for chronic heart failure. Again, the respondent results for this question had a significant do-not-know response rate (58.8%). The do-not-know responses were removed from the two-sided Fisher's exact test cross tabulation. Once broken into hospital type, no significant statistical result existed ($p = .49$; see Tables 31 and 32). The large do-not-know response provided further insight that hospital administrators were unaware of organizational performance.

Table 31

Hospital Type–Chronic Heart Failure Cross Tabulation

Hospital type	Chronic heart failure		Total
	Yes	No	
Academic	3	0	3
Community	6	4	10
Small	4	1	5
Total	13	5	18

Table 32

Fisher's Exact Test of Hospital Type and Chronic Heart Failure

	Value	df	<i>p</i> (two-sided)	Exact <i>p</i> (two-sided)
Pearson chi square	2.05	2	.36	.49
Likelihood ratio	2.81	2	.25	.41
Fisher's exact test	1.61			.49
<i>N</i> of valid cases	18			

OP6: Readmission rates for diabetes. The respondent results for this question had a considerable do-not-know response rate (56.9%). The do-not-know responses were removed from the two-sided Fisher's exact test cross tabulation. Once broken into hospital type, no significant statistical result existed ($p = 1.0$; see Tables 33 and 34). As in the other five organizational performance variables, the large do-not-know response rates represented the lack of awareness by hospital leaders on how they were meeting required LHIN performance measures.

Table 33

Hospital Type–Diabetes Cross Tabulation

Hospital type	Chronic heart failure		Total
	Yes	No	
Academic	2	0	2
Community	7	2	9
Small	6	1	7
Total	15	3	18

Table 34

Fisher's Exact Test of Hospital Type and Diabetes

	Value	df	p (two-sided)	Exact p (two-sided)
Fisher's exact test	.68			1.00
Likelihood ratio	.94	2	.62	1.00
N of valid cases	18			
Pearson chi square	.63	2	.73	1.00

The responses to the questions on six organizational performance measures were overwhelmingly returned with the do-not-know answer, which was treated as missing data and removed from the analysis. Analysis using a two-sided Fisher's exact test of the small number of remaining responses returned no significant results. The results indicated that hospital administrators did not have the knowledge necessary to determine whether they were meeting strategic expectations as set by the LHIN and MOHLTC in the *Hospital Accountability Agreement*. This is of concern, because hospital administrators might be assigned penalties in the form of budget cutbacks or sanctions placed upon the

hospital board for not meeting the agreed upon organizational performance conditions. Future inability to meet *Hospital Accountability Agreement* agreements could result in further health-care policy reforms by the provincial government. As none of the results from the data analysis were significant, the null hypothesis is not rejected.

Hypothesis 3

H3₀: There is a relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

H3: There is no relationship between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

The large do-not-know responses drastically reduced the sample size for analysis. In all cases, the response of *do not know* was considered missing data and not included in the analysis. To ascertain whether any significant results could be discovered, the Kruskal-Wallis test statistic was used. Each of the organizational performance variables was considered against the five strategic planning patterns. All statistical tests had an alpha level of .05.

Myocardial infarction and strategic planning pattern. The Kruskal-Wallis test statistic was conducted to evaluate differences between strategic planning pattern and myocardial infarction. No significant results emerged from this analysis (see Table 35). The do-not-know response rate was 56.9% and those results were removed from the data set (see Table 36).

Table 35

Test Statistics for Myocardial Infarction and Strategic Planning Pattern

	LHIN focused	Regional focused	Independent	Performance focused	Team based
Chi square	.35	.19	.01	2.39	2.15
<i>df</i>	1	1	1	1	1
<i>p</i>	.55	.66	.90	.12	.14

Table 36

Ranks for Myocardial Infarction and Strategic Planning Patterns

	<i>N</i>	Mean rank
Factor 1: LHIN focused		
Yes	13	9.92
No	7	11.57
Factor 2: Regional focused		
Yes	13	10.08
No	7	11.29
Factor 3: Independent		
Yes	13	10.62
No	7	10.29

Table 36 (continued)

	<i>N</i>	Mean rank
Factor 4: Performance based		
Yes	13	9.00
No	7	13.29
Factor 5: Team based		
Yes	13	11.92
No	7	7.86

Chronic bronchitis and strategic planning pattern. The Kruskal-Wallis test statistic was conducted to evaluate differences between strategic planning pattern and chronic bronchitis. The analysis did not include in any significant results (see Table 37). The do-not-know response rate was 66.7% and those results were removed from the data set (see Table 38).

Table 37

Test Statistics for Chronic Bronchitis and Strategic Planning Pattern

	LHIN focused	Regional focused	Independent	Performance focused	Team based
Chi square	.49	.49	.01	1.02	.30
<i>df</i>	1	1	1	1	1
<i>p</i>	.48	.48	.94	.31	.59

Table 38

Ranks for Chronic Bronchitis and Strategic Planning Patterns

	<i>N</i>	Mean Rank
Factor 1: LHIN focused		
Yes	11	7.91
No	3	6.00
Factor 2: Regional focused		
Yes	11	7.91
No	3	6.00
Factor 3: Independent		
Yes	11	7.45
No	3	7.67
Factor 4: Performance based		
Yes	11	6.91
No	3	9.67
Factor 5: Team based		
Yes	11	7.18
No	3	8.67

Chronic heart failure and strategic planning pattern. The Kruskal-Wallis test statistic was conducted to evaluate differences between strategic planning pattern and chronic heart failure. The analysis did not result in any significant results (see Table 39). The do-not-know response rate was 58.8% and those results were removed from the data set (see Table 40).

Table 39

Test Statistics for Chronic Heart Failure and Strategic Planning Pattern

	LHIN focused	Regional focused	Independent	Performance focused	Team based
Chi square	.55	.29	.06	.02	2.33
<i>df</i>	1	1	1	1	1
<i>p</i>	.46	.59	.80	.88	.13

Diabetes and strategic planning pattern. The Kruskal-Wallis test statistic was conducted to evaluate differences between strategic planning pattern and chronic heart failure. The analysis included one significant result for performance-based strategic planning pattern ($H[1, N= 18] = 4.30, p = .04$; see Table 41). The do-not-know response rate was 56.9% and those results were removed from the data set (see Table 42).

Table 40

Ranks for Chronic Heart Failure and Strategic Planning Patterns

	<i>N</i>	Mean rank
Factor 1: LHIN focused		
Yes	13	10.08
No	5	8.00
Factor 2: Regional focused		
Yes	13	9.92
No	5	8.40
Factor 3: Independent		
Yes	13	9.69
No	5	9.00
Factor 4: Performance based		
Yes	13	9.62
No	5	9.20
Factor 5: Team based		
Yes	13	8.31
No	5	12.60

Table 41

Test Statistics for Diabetes and Strategic Planning Pattern

	LHIN focused	Regional focused	Independent	Performance focused	Team based
Chi-square	.03	.09	.00	4.30	1.27
<i>df</i>	1	1	1	1	1
<i>p</i>	.86	.77	.95	.04	.26

Table 42
Ranks for Diabetes and Strategic Planning Patterns

Factors	N	Mean rank
Factor 1: LHIN focused		
Yes	15	9.60
No	3	9.00
Factor 2: Regional focused		
Yes	15	9.33
No	3	10.33
Factor 3: Independent		
Yes	15	9.47
No	3	9.67
Factor 4: Performance based		
Yes	15	10.67
No	3	3.67
Factor 5: Team based		
Yes	15	8.87
No	3	12.67

The results from the analysis are not conclusive. The one significant result was between performance-based hospital leaders and diabetes. Because diabetes was a major focus of the LHIN's chronic care disease management (MOHLTC, 2008), the hospital leaders built performance expectations into their strategic plan as outlined in the *Hospital Accountability Agreement*. In this case, diabetes has been a successful focus for the

hospital administrators. The MOHLTC has given a great deal of attention to the diagnosis and treatment of diabetes over other chronic diseases such as chronic bronchitis and chronic heart failure, so it is not unexpected that the performance-based hospital leaders have placed a greater emphasis on managing diabetes readmissions in their hospitals.

Although the data analysis contained one significant result, there was no consistency to any of the strategic planning patterns. The performance-based factor only met performance expectations in one chronic disease site, and did not produce significant results in other financial and clinical performance measurements. A high do-not-know response rate marginalized the results from the data analysis. Thus, the results do not support rejection of the null hypothesis. No relationship appeared to exist between hospital performance and use of an identifiable strategic planning framework used by acute-care hospital senior administration teams in Ontario.

Research Question 4

What is the correlation, if any, between strategic planning and hospital performance in Ontario acute-care hospitals?

Upon examining the results of organizational performance against hospital type (small, community, and academic) and against the five strategic planning patterns, no correlation existed between strategic planning and hospital performance. The five strategic planning patterns provided insights into how hospital leaders might focus their attention on certain elements of the health-care environment to the detriment of other components of strategic planning needed for successful outcomes. Small hospitals were noteworthy in that they were inversely significant for the independent strategic planning pattern.

It became apparent through the data analysis that hospital administrators had little knowledge of formalized strategic planning methods or of how their organization performed in the performance categories, especially clinical, required by their regional LHIN, and did not have a clear understanding of what the regional LHIN administration required of the leadership team. Only 70% of hospital leaders replied that they had determined specific actions that would assist them to meet predetermined targets in the *Hospital Accountability Agreement* performance indicators. Twenty percent of leaders stated they have not made these efforts, and 10% of leaders did not know if these actions had taken place. How much emphasis hospital leaders placed upon on LHIN *Hospital Accountability Agreement* performance indicators is uncertain. Budgetary concerns might have received greater weight by administrators than clinical performance as indicated by the greater knowledge of nursing ratios (salaries) and current ratios than clinical performance (readmission rates for myocardial infarction, chronic bronchitis, chronic heart failure, and diabetes).

Research Question 5

Which types of hospital performs better than others and which, if any, of the three strategic planning principles (environmental scanning, strategy formation, and implementation) are used?

When examining which hospitals may perform better than others, the results showed that all hospitals were in the same state, and none were meeting expectations as determined by the *Hospital Accountability Agreement*. This result was somewhat surprising because academic hospital administrators possess greater human resources, and an expectation is that they would have an improved ability to strategically plan,

evaluate, and measure their organization's progress during the life of the strategic plan. The data showed otherwise, and leaders of academic hospital were no more successful in performing than were leaders of small hospital.

Participants stated during P1 and respondents confirmed in P2 that strategic planning was not a formalized process in Ontario acute-care hospitals. Some planning patterns utilized strategic planning principles more than others did, but none was consistent in their usage and none of the patterns utilized all three of the principles uniformly. Strategic leadership by hospital administrators was not consistent, which led to difficulties during implementation of the strategic plan and a lack of buy-in to the plan by organizational stakeholders. Hospital leaders relied upon outside organizations to provide environmental scanning data on a periodic basis, which is concerning for a rapidly aging and diverse population. Data might not be relevant to their specific community population, and hospital leaders used assumptions to make strategic decisions, at a potential cost to the hospital of miscalculating local patient-care needs.

Many hospital leaders recycled strategic goals if, as a participant stated, "they are still relevant." This practice indicated that hospital strategic plans were not designed to meet goals within a specific period that strategic planning was an activity of little substance, and goals were operational in nature than strategic. The inability of hospital leaders to measure progress made in moving toward goals might have impeded the leaders' ability to meet the goal within the time frame of the strategic plan. The lack of participation of key hospital leaders and stakeholders in the strategic plan (COO, nurse, and physician leaders) might also derail strategic goals, and important information was missing on whether goals are needed, realistic, and achievable.

Hospital leaders, regardless of hospital type or the format of strategic planning utilized, were mostly unaware of the organizational performance and did not routinely utilize standard strategic planning principles. Such behavior could cause these leaders difficulty in meeting expectations by the MOHLTC and the regional LHIN.

Phase 2 Summary

The purpose of the quantitative portion of the study was to gather information on the perceptions and behaviors of senior hospital leaders when strategic planning. Described in this section were the data collection procedures and an analysis of the data. Using a Likert-type survey developed from information gathered during the qualitative portion of the study and current strategic planning theory, acute-care hospital leaders provided information regarding their use of strategic planning principles, strategic leadership application, organizational behavior characteristics, and the influence of provincial health-care funders and stakeholders. The use of factor analysis served to isolate respondent data into five strategic planning patterns. Respondents' information on their ability to meet MOHLTC and LHIN performance expectations underwent further evaluation by ANOVA and nonparametric tests to determine if any relationships existed between strategic planning patterns, hospital type, and organizational performance.

The data analysis from P2 indicated no consistency existed in strategic planning patterns practiced by senior leadership teams of acute-care hospitals in Ontario. Hospital leaders are unaware of their performance in managing chronic disease. Neither strategic planning patterns nor hospital type produced significant results when examined with organizational performance. An inverse relationship was demonstrated when examining the independent strategic planning pattern and small hospitals. Only one clinically

significant result was noted (performance-based and diabetes), but leaders of this strategic planning pattern were unable to reproduce the positive results with other clinical indicators. Even these results were circumspect as most of the hospital leaders were unaware of their hospital's performance in patient readmissions for chronic disease and the majority of responses, *do not know*, were deleted from the data set as missing information.

Certain hospital leaders were excluded from the strategic planning process, which can affect the ability of other strategic planners to understand how best to utilize resources. Thirty-four percent of existing strategic plans were more than 4 years old. The strategic planning process was informal, and the review process of the strategic plan was nonstandardized and inconsistent.

Conclusion

In chapter 4 included an examination of acute-care hospital leaders' perceptions of strategic planning and their behaviors when planning using qualitative focus groups, a quantitative survey, and current strategic planning theory. The study included the use of coding methods to show associations of leaders' perceptions in relation to strategic planning principles, relationships with stakeholders, strategic leadership, and organizational performance. An expert panel, independent coder, and piloting team of hospital administrators assisted in creating an instrument used to determine if hospital leaders used any strategic planning patterns. Factor analysis served to identify five strategic planning patterns. ANOVA and nonparametric tests (Fisher's exact test and Kruskal-Wallis) were used for data analysis of the survey responses. Three hypotheses were examined, and in all cases, the results led to a failure to reject the null. No

correlations existed between organizational performance and hospital type (small, community, academic) or strategic planning patterns.

Data analyses from both P1 and P2 of the study clearly identified that no formal, standardized method of strategic planning existed in the Ontario acute-care hospital system. Regardless of hospital type and access to resources, hospital administrators' use of the strategic planning principles environmental scanning, strategy formation, and implementation were inconsistent. Hospital leaders were overwhelmingly uninformed of their own organization's performance, especially in clinical areas. Key hospital leaders did not routinely participate in the strategic-planning process.

Chapter 5 will include a discussion of the research findings and a comparison of strategic planning theory and the qualitative and quantitative study findings. Insights gathered from the data analysis provide an appraisal on strategic leadership practiced by acute-care hospital leaders. Also included in the chapter 5 discussion are recommendations to the OHA and acute-care hospital leaders and suggestions for future research.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

The acute-care hospital system in the Province of Ontario has undergone several reforms since 1990. Despite multiple reforms, the government and leaders of hospital organizations still struggle with maintaining an excellent patient-care system with restricted financial resources (Evans, 2004). The methods acute-care hospital administrators practiced to plan strategically in delivering patient-care services in these environmental conditions has not been clear. Because no research existed in Canada on hospital senior teams' strategic and decision making activities, it was unknown if decision making was strategic or if planning and decision making resulted in positive performance change.

The study had two purposes. The first was to understand whether acute-care hospital administrators in Ontario used strategic planning, and if so, how administrators used strategic planning and whether planning differentiated by hospital type. The second purpose of the study was to explore relationships between strategy, hospital type, and organizational performance at the acute-care hospital level. Independent variables for the study were strategic planning and hospital type (academic, community, and small). The dependent variable was organizational performance (financial current ratio, full-time equivalent nursing, and readmission rates for myocardial infarction, chronic bronchitis, diabetes, and chronic heart failure).

Moving organizations forward requires strategic leadership. In research on strategic choice, Child (1972) outlined how decisions made by senior leaders influenced stakeholders' perceptions of the organization, the evaluation of the organizational structure, and how organizational leaders responded to the environment. Results from the

study indicated that Ontario hospital leaders did not use strategic planning principles consistently and had not developed best practice methods to meet and satisfy strategic goals. Hospital leaders were unaware of whether they met Local Health Integrated Networks (LHINs) and Ministry of Health and Long-Term Care (MOHLTC) performance criteria. The lack of knowledge by administrators created a situation where the senior leadership team was unable to satisfy stakeholder expectations and to respond adequately to environmental changes.

As no research existed in Canada on how acute-care hospital leaders approached strategic planning, a mixed-methods study was appropriate. The qualitative P1 of the study involved the use of four focus group sessions to gain a perspective on how hospital administration teams from different types of Ontario acute-care hospitals viewed the context of strategic planning and what methods, if any, the team applied to create the strategic plan. Using information from those sessions and current strategic planning theory, a quantitative Likert-type survey was developed (P2). Hospital leaders of a fifth Ontario hospital piloted the survey. Feedback from the hospital executives resulted in various wording changes and additional questions. Leadership teams from 114 acute-care hospitals in Ontario received the final survey. The survey results underwent factor analysis, ANOVA, and nonparametric tests. Chapter 5 includes a discussion on the following subtopics: (a) interpretation of the research findings; (b) study limitations; and (c) implications for future research, policy makers, and hospital administrators. The generalizability of the research findings is limited to the province of Ontario due to the specific design of healthcare administration within this province. As other Canadian

provinces have different methods of health care regionalization, the study findings may not be applicable to other hospital organizations outside of Ontario.

Research Findings

The research process included an investigation of five research questions and three hypotheses. The data collected in the qualitative, pilot, and quantitative studies resulted in several insights on how hospital leaders approached strategic planning, where their concerns lay in the strategic planning process, how hospital leaders met predetermined organizational performance requirements, and the recognition of five distinct strategic planning patterns used by hospital administrators. None of the study null hypotheses were rejected (see Table 43). Following is a discussion of the research questions and hypotheses related to current strategic theory.

Table 43

Study Null Hypotheses

Null hypothesis	Support or rejection of null
H1 ₀ : Hospital type (academic, community, or small) is not related to use of an identifiable strategic planning framework.	Supported
H2 ₀ : Hospital type (academic, community, or small) is not related to hospital performance	Supported
H3 ₀ : There is no relationship between hospital performance and use of an identifiable strategic planning framework	Supported

Qualitative (Phase I)

The study involved determining if strategic planning best practices existed among hospital leaders. During the focus group sessions, hospital administrators reflected on the processes they undergo when entering the strategic planning phase where improvements can be made to meet expected performance outcomes. When hospital leaders outlined their planning methodologies, there were distinct omissions from the strategic planning principles of environmental scanning, strategy formation, and implementation. As hospital leaders are expected to bridge expectations of government policy makers, community interests, health-care providers, and patients (Brown et al., 2006), the lack of systematic and consistent strategic planning methodologies created additional challenges to hospital leaders to meet expected organizational performance goals as determined by the MOHLTC and LHIN.

Research Question 1

What is the content and context of strategic planning from the perspective of hospital administrators and does strategic planning within this environment emulate other strategic planning methods or theories?

Context of strategic planning. The qualitative focus groups revealed that hospital administrators believed the strategic planning context was a form of vision development, or a method used to create movement forward. One definition of strategy was a “tool or mechanism to achieve mission” (Senior Management Team [SMT]01). Yet the examples senior hospital leaders provided to describe their strategic goals reflected operational management and not organizational strategy. The leaders did not actively incorporate the mission of the hospital, to provide excellent patient care, into the strategic goals set by

hospital planners. With the introduction of the regional LHINs, hospital leaders voiced concern that the mandate and mission of the hospital would change, and hospital leaders and boards would “lose autonomy to decide what we necessarily think may be the best services to provide our community” (SMT01).

Findings in the study indicated that few hospital leaders attempted to differentiate their hospital services from other health-care providers in their region. In research on Canadian hospital executives’ processes to develop hospital mission statements, Bart and Hupfer (2004) noted that hospital leaders did not associate a market focus in the mission to differentiate their organization from others. Instead, Bart and Hupfer found that hospital executives determined they had competitive orientation when their hospital core competences met patient needs. Although the type or format of mission statements cannot be linked specifically to organizational performance (Bart & Tabone, 2000), mission statement dissemination does have an association with providing direction to hospital middle managers leading to better performance (Butcher, 1994). The challenge that Bart and Hupfer found in their research was that Canadian hospital executives viewed the mission statements in a narrow context and treated the items in the mission statement as a “mental checklist” (p. 105). As confirmed in the current study, a deficit of measurement models exists in Ontario acute-care hospitals and strategic plan evaluations became an exercise in checking off boxes. Hospital executives cannot manage what they do not measure.

Because hospital acute-care leaders in Ontario admitted that they use checklists to determine if hospital strategy and mission were met, what form of strategy ensued from this behavior was questionable. Mintzberg (1978) identified three primary forms of

strategy: intended, emergent, and imposed. The elements of strategy formation as perceived by the hospital leaders were a blending of two of these strategy forms. Intended strategy for the hospital leaders and their boards involved setting goals to move the organization forward to provide fiscally responsible patient care. An expectation by regional LHIN administrators that acute care leaders would incorporate components of the LHIN strategy into their own hospital strategy indicated an imposed strategy. As hospital leaders' goal was to fit hospital programs into financial resources available on an operational level, the best description of strategy might be absent strategy (Inkpen & Choudhury, 1995).

The purpose of the health-care professionals within the acute-care hospital environment was to manage patients' health, although the focus of many hospital leaders participating in P1 was to meet financial obligations set by the LHIN. Inkpen and Choudhury (1995) described three types of absent strategy: absence as failure, absence as transition, and absence as virtue. Absence as a failure related that bad strategy led to poor organizational performance. Because the focus of the definition of strategy by hospital leaders was how to fit patient care around financial resources, little energy went toward how to improve patient care within the financial resources available. Also reflected in the behavior of Ontario acute-care hospital leaders was absence as transition, as confusion existed regarding the expectations of the relatively new LHINs. Without clarification of the LHIN strategy, and how the strategy merged into the strategy of the acute-care hospital environment, leaders of the organizations were in a situation of not knowing how to strategically plan. The final category, absence of virtue, was not applicable with the

leaders, as none of them was refusing to create strategy for their hospitals based upon a conscious decision of inaction.

Because hospital leaders were raising concerns about the autonomy of the acute-care environment and the new expectations of revenue generation, a question existed regarding whether the Ontario government was increasing traits of what other countries term managed care. The provincial health-care systems in Canada all must adhere to government-funded medical coverage (Canada House of Commons, The Canada Health Act, 1984). Managed health care provides health coverage that is flexible and gives a choice of health-care providers while controlling rising costs (Tisdale & Liberman, 2002). Numerous examples of managed care strategies are available (Lutz & Foong, 2008; Mittelstaedt, Duke, & Mittelstaedt, 2009; Simonet, 2007) and the MOHLTC might be imposing further restrictions upon hospital finances to increase efficiencies within hospitals. Based on the responses of the focus group participants, this type of management thinking, much less strategically planning under a managed model, was not part of their collective consciousness.

The hospital leaders noted the strategic planning process was informal and unstructured, and no evidence was available of the attention required on a senior management level to produce a plan that would meet perceived environmental fluctuations. The historical funding of Ontario hospitals produced an enabled strategy in which hospital leaders and boards had the ability to produce unrealistic budgets and the provincial government enabled the strategy, which covered all resulting deficits to maintain patient care. The new LHIN accountability of meeting specific budgets and organizational performance measures moved hospital leaders outside of the comfort of

previous behaviors. Hospital senior teams did not have an understanding of how health-care policy had changed in the province, did not have the skills required to create strategic plans to align with those changes, and were unaware of how to change the business model to mold with the new funding and accountability structures. Hospital senior teams were lacking skills in change management that would assist them to redesign the strategic plan in accordance with the emerging LHIN health-care environment.

Environmental scanning. Hospital administrators admitted that environmental scanning was haphazard. Environmental scanning was “probably a foreign concept to most people in hospitals” (SMT01). Assumptions and presumptions regularly guided strategic behavior instead of qualitative and quantitative analysis of population health needs. Retrospective data from external sources was the predominant source of environmental scanning information, which was concerning in that the data collected from external sources was developed with the usage and needs of the collecting source in mind and not for the use of alternative health-care organizations. Information gathered by hospital organizations might not translate into the perspective of the acute-care health-care environment and thus might not be relevant to the needs of the population serviced by that hospital group.

Three observations resulted from the focus group discussions. First, hospital leaders did not have a clear understanding of the importance of environmental scanning. Hospital administrators’ approach to this strategic planning principle was, by their admission, inconsistent and nonstandardized. As previously noted in this chapter, the basis for the structure of strategic planning was the financial management of the hospital,

which left organizational units and programs vulnerable to budget cuts or closures (Layman & Bamberg, 2005). Without a full environmental scan, hospital leaders are unable to ascertain whether the quality of the strategy is sufficient to meet both internal and external environmental conditions (Hambrick & Fredrickson, 2005). As the focus of the LHIN orientation of health-care delivery is meeting community health needs, environmental scanning would help hospital leaders develop a community orientation and result in identifying and meeting patient needs (Ginn & Lee, 2006).

Second, without environmental scanning using both internal and external epidemiology statistics, health-care leaders cannot advocate to the LHIN and MOHLTC for additional funds to meet increasing community health needs. Hospital administrators related that scanning activities generally became information gathering from outside agencies such as the LHIN, Canadian Institute of Health Information (CIHI), Community Care Access Centers, Statistics Canada, and other governmental or health-care bodies that collected epidemiological or demographic data. Two of the focus groups mentioned trending recent hospital admissions as a way of tracking disease progression needs, but that the activity was sporadic. Leaders of small hospitals commented that they did not have the staff to do much scanning activity. Previously, hospital administrators would appeal to the MOHLTC for additional funds to cover increased patient costs (Gehman, 2002); however, under the new funding formulas, hospital administrators are not permitted to appeal for this activity. Thus, without diligent scanning of disease morbidity, hospital leaders are unprepared and underfunded to manage their community's health needs.

Third, whether hospital leaders understood the importance of determining their own organizational internal skills and competencies remained uncertain. Hospital administrators revealed the lack of a targeted internal scanning process to identify organizational strengths and weaknesses and to identify competencies or deficiencies in patient care. As health-care standards of care are constantly changing, health-care professionals should maintain competency in skill sets, especially as patients transfer from one hospital to another (Axley, 2008). Hospital administrator participants expressed concern about the removal of patient services from their organizations. Without ensuring that the hospital staff brings skills and competencies to the organization, it becomes more difficult to argue with the LHIN for the maintenance of patient services. Without identifying internal strengths and weaknesses, hospital leaders lacked sufficient knowledge to create cost efficiencies in patient-care programs.

The necessity of environmental scanning in the strategic planning process is twofold. First, if the hospital leaders use intended strategy as the methodology, the strategic goals must fit within the health-care environment for successful outcomes. Second, if the strategy is emergent, strategy formulation must have flexibility to adapt to recognized fluctuations within the environment. As hospital leaders place little emphasis on understanding the environment that they are expected to adapt their strategic plan toward, it is difficult for senior teams to modify their organizational behavior to meet expected performance outcomes.

Strategy formation. A central element in generic management theory is the concept that strategy content influences organizational performance (Balogun & Johnson, 2005; Meier, O'Toole, Boyne, & Walker, 2007). Strategy formation builds upon

information gained from environmental scanning to determine how an organization adapts to the environment to meet specific goals (Jennings & Disney, 2006; Mintzberg, 1978). Because hospital leaders admitted that environmental scanning was informal and inconsistent, the quality of strategy formation is circumspect. As discovered during the focus group sessions, strategy formation tends to involve recycling strategic goals from previous strategic plans. Strategic goals developed by hospitals were operational in nature and not intent on setting visionary benchmarks for organizational growth and development. If the operational goal was not met but still felt to be relevant, hospital administrators carried the goal over to the next strategic plan. Hospital leaders' assumptions and presumptions on local population health needs guided decision making, which again reflected the lack of environmental scanning.

Martin et al. (2003) outlined an example of this format of strategic decision making during a strategic planning initiative at Sunnybrook & Women's College Health Science Center in Toronto, Ontario. The purpose of the research was to understand whether conditions of accountability for reasonableness assisted in priority setting. Sunnybrook strategic planners invited a large number of clinical and nonclinical participants to assist in determining the priorities for the hospital strategic plan. The goal of the exercise was "to operationalize the strategic directions within the fiscal realities of the organization" (Martin et al., p. 199). Despite volumes of information provided to participants, Martin et al. noted that not one part of the process included "information about community initiatives, Ministry of Health funding calculations, and educational priorities originating at the university that might influence prioritization of the hospital's clinical programmes" (p. 199). Martin et al. also reported that informal communication to

staff about the initiative was through word of mouth. Prior to the strategic planning sessions, little communication with the MOHLTC, university, other health-care providers, or community links took place. Martin et al.'s aim in the research was to improve priority setting through fairness, although evidence existed of the total lack of recognition by both the Sunnybrook strategic planners and Martin et al. that vital components of strategic formation were missing from the planning process that would make the strategic plan successful.

Participants in the study stated repeatedly that they did not have a clear understanding of LHIN executive expectations. Some terms used by LHIN administrators, such as community engagement and integrated care, left hospital leaders uncertain about the meaning of the terms and unsure how to apply the concepts into strategic planning. The MOHLTC had not provided explicit direction to hospital leaders on policy changes taking place (Brown et al., 2006). The concerns that hospital leader participants expressed over the LHIN requirement to incorporate community engagement and integrated care indicated that hospital leaders had become institutionalized in their strategic planning structure, where managerial perceptions influenced the strategy-making process (Giddens, 1979, 1984; Bloodgood & Morrow, 2000; Pozzebon, 2004). As a result, hospital leaders had focused strategy formation inward and ignored the larger system integration (Brown et al., 2006). The strategic planning structure that the LHIN and MOHLTC were advocating was networking (Blackler, Crump, & McDonald, 2000; Ellis & Mayer, 2001; Sydow & Windeler, 1998), where hospital leaders organized their interorganizational relationships and arrived at strategic decision making through accumulated interactions.

The history of independent hospital boards in Ontario brought power, legitimacy, and organizational sense making to the strategy table in a way that was not conducive to networking and integrated health strategic planning (Maitlis, 2005; Sydow & Windeler, 1998). Thus, the new way of conceptualizing and structuring strategy formation under the LHIN structure was foreign to hospital leaders, as indicated in the participants' comments about their confusion over the LHIN's requirements that strategic planning should be performed with a regional approach, and they feared losing autonomy over patient service delivery. Although the MOHLTC and LHIN determine the services that acute care hospitals provide, health-care leaders could meet on a regional basis to determine how to coordinate their patient-care delivery to maximize resources and improve care services.

The importance of developing a balanced budget became the central focus for hospital leaders when developing strategic goals and achieving organizational performance goals. Jennings and Disney (2006) noted that organizations must have a balance between adaptation (promotion of creativity using environmental scanning) and integration (managing and coordinating internal resources). Adaptation includes a participative approach to strategic goal setting with loose linkages to business unit budgets. Integration requires goal setting to be a top-down approach, with the emphasis on operating versus strategic budgets and tight linkages to budgets. Instability in organizational performance is associated with strategic planning processes that reflect the inability of senior leaders to maintain organizational control (Jennings & Disney). When the organizational strategic goals are grossly operational in nature, the focus on budgetary

matters and integrated approaches contributes to the lack of performance in patient care (Jarzabkowski, 2008; Porter, 1996).

Implementation. Hospital leaders discussed techniques they employed to promote participation by hospital stakeholders as part of the strategic plan implementation. The techniques included forming continuous quality improvement teams, requiring functional area managers to develop tactical plans for strategic plan implementation in their areas, and hospital-based decision making bodies accountable to the senior team and the board on operational actions. As many of the strategic goals for the organization are operational in nature, relating this strategy to the hospital environment as a whole led to implementation difficulties (Shimizu & Hitt, 2004). Focus group participants readily admitted they had difficulty engaging hospital professional staff, especially physicians, to buy-in to the strategic plan. This was concerning as physicians are the greatest users of resources within the hospital.

Strategy implementation was dependent upon the resources available for the hospital. Some hospital administrators had greater resources available to place individuals in positions of environmental scanning and implementation. The training that these individuals received to accomplish these tasks is unknown. Considering that strategic goals were constantly recycled from one strategic plan to another, hospital leaders' expectations of achieving the strategic plan is underwhelming. The reintroduction of strategic goals from one plan to the next sent a strong signal to hospital stakeholders that the plan is not well developed and their efforts will not be beneficial to achieving the goal (Lines, 2007). No plan existed to ensure a consistent implementation of the strategy. "It was presented to the staff and then the strategic goals. . . . [T]hey were

shown how the strategic directions developed between the hospital goals and objectives, and they in turn take it to their departments and develop departmental goals and objectives” (SMT04). When reliant upon each individual manager’s interpretation of the strategy to create tactical and strategic goals to support the organizational initiatives, hospital leaders ran the risk of functional areas working at cross-purposes and achieving none of the strategic objectives.

Until recently, the nature of the Ontario health-care system negated the importance of strategic implementation. The dependency relationship acute-care hospital leaders had for funding with the MOHLTC created a barrier to a thorough implementation plan. A competitive environment, where active solicitation of patients takes place, did not exist; the MOHLTC restricted the number and type of hospitals and patients went to the closest hospital with needed services (Ontario Legislative Assembly Health Care Services Act, Bill 94, 1985). Until 2006, the ministry relieved hospital budget deficits so that patients continued to receive care in their community. Hospital leaders were not worried about developing a strategic plan to ensure long-term survival and success (Pryor et al., 2007). Thus, when discussing strategy implementation with focus groups, no participants made any comments about organizational learning or understanding organizational culture aspects that could be detrimental to the implementation process. None of the participants commented on what they would do if implementation fails, most likely because strategic goals were usually recycled. The discussion did not include any mention of ensuring that the skills and competencies were in place in the hospital to support implementation of the goals.

The nature of the Ontario health-care environment changed with the introduction of the LHINs. With a regional intermediary demanding accountability on how hospital leaders provide services to their communities, administrators and hospital boards are under pressure to meet performance expectations. Ontario is the only province where individual hospital boards still exist with the responsibility for developing a strategic plan to provide timely and cost-efficient health care. Unless hospital administrators can show they have the skills to improve patient outcomes within set fiscal limitations, there is an impending risk that hospital boards will be dismantled and, like other provinces, regional health authorities will determine the strategic design for hospital leaders.

One question within the study was whether the strategy was intended, emergent, or imposed (Mintzberg, 1978). As each strategic plan reclaimed many strategic goals from the previous plan, intended strategies were elusive. Because the majority of stated strategic goals were operational in nature, it was even questionable if the goals could be termed strategic. The hospital leaders did not describe what would be termed emergent strategies, as administrators stated they did not change the strategic plan or goals to respond to environmental changes. The requests by the LHIN to include portions of the LHIN's strategic plan within the hospital strategy indicated some form of imposed strategy. Yet hospital leaders were unsure of the relevancy of the LHIN goals to the provision of acute care and were reluctant to assume strategic vision from a government source.

Organizational performance measurement. An important factor of introducing the regional LHIN was to bring accountability to acute-care hospitals in their organizational performance, both on financial and clinical levels (Ontario Legislative Assembly Local

Health System Integration Act, Bill 36, 2006). When asked about the use of performance measurements within their hospitals, hospital leaders became uncomfortable. One hospital group had set a strategic goal to create organizational performance measures. Hospital leaders relied upon outside agencies to provide a report card on the organizational performance. Physician and staff satisfaction scores were another indicator hospital leaders looked to as a measure of internal performance. Hospital leaders admitted to using the concepts of monitoring and measuring interchangeably, and in many cases, organizational performance was simply a matter of ticking off a box rather than setting targets and expectations.

Hospital leaders were still in the early stages of developing formalized organizational performance measures, which was surprising as the MOHLTC contracted individuals from the University of Toronto (G. R. Baker & Pink, 1995, Baker et al., 1998, 1999) in the mid-1990s to develop a balanced scorecard for acute-care hospitals and encouraged hospital leaders to implement this strategic tool. Subsequent follow-up on the use of the balanced scorecard by hospital leaders found that only 23% of acute-care hospitals used some form of system-developed scorecard (Yap et al., 2005). Academic hospital leaders were more likely to implement some variation of scorecard in their organizations, followed by community hospital leaders. Yap et al. hypothesized that small hospitals were least likely to implement a scorecard due to lack of resources. Absence of the balanced scorecard might be due to hospital leaders not receiving training in how to use the tool. Regardless, none of the hospital focus groups had adequate performance measurement systems developed as part of the strategic plan implementation.

As described by hospital leaders, the context of strategic planning and use of strategic planning principles related to a bygone era, when hospital leaders and boards were able to isolate themselves from other regional health-care partners, had little accountability for patient outcomes, and had an assurance that funding would be available regardless of the scarceness of provincial resources. Strategic planning had been primarily a required exercise, with little formality or expectation of concrete results. Although one expectation of the data analysis was that small hospitals and community hospitals to some extent have greater challenges in attaining all the resources necessary for successful strategic planning, the revelation that academic hospitals were as challenged in understanding the requirements of strategic planning was surprising. The driving force of operational goals as strategic highlighted the continuing conundrum that hospital leaders face in producing improved patient outcomes. The lack of linkages between cost efficiencies and patient care was concerning, as the primary customer of the hospital—the patient—was all but forgotten in the elusive quest for fiscal management.

Research Question 2

What do hospital administrators view as best practices in strategic planning (presuming that the planning takes place)?

Process. All the participating hospital leaders believed that the strategy formation process they used followed a formalized structure, although the structure was inconsistent. Some leaders admitted that hospital strategic planning was more crisis management than proactive strategy. Hospital leaders stated that the LHIN expected strategic planning at the hospital level would incorporate regional health concerns through community engagement. What hospital leaders viewed as best practices in

strategic planning did not always translate to active practice when performing strategic planning. From the reflections of the focus group participants, it was evident that hospital leaders thought they understood how to do strategic planning, yet did not understand why the strategic plan was not successful. Hospital leaders, regardless of hospital type, approached strategic planning with the same mind-set and same methodology as for previous strategic plans. This behavior occurred regardless of whether the previous strategic practices were successful in meeting hospital goals and the new LHIN health-care environment.

Hurtado (2006b) linked the concept of strategy to problem solving. The strategy is a set of solutions to current issues that lead to an improvement in business effectiveness (Hurtado, 2006b). Different methods of the strategy process exist. The traditional planning method matches organizational competencies to environmental conditions (Mintzberg, 1978). The traditional method passively predicts the environment the organization will inhabit in the near future (Hurtado, 2006b). The scenario-planning method opens leaders to imagine several futures. Causal modeling, design of managerial cultures, and intervention methodologies open the strategic planning process to examine the possibilities of manipulating the environment (Hurtado, 2006b). Emergent strategy comes from the leaders' belief that the future environment is unknown and unpredictable (Mintzberg, 1978). A successful emergent strategy matches the strategy to the emerging environmental conditions (Mintzberg, 1978).

Hospital leaders were looking for methods to improve organizational efficiencies, although there was not necessarily a focus on moving toward effectiveness.

Organizational efficiencies in hospitals results from effectiveness using rationalization

and standardization of primarily clinical procedures (Lefton, 2008). Hospital leaders were inconsistent when performing environmental scanning and performed scanning primarily when developing the strategic plan. Strategic goals carried forward from plan to plan, which negated the concept of developing strategic goals that would meet future organizational needs. Hospital leaders did not make use of scenario planning, as there was no reflection on how to change the organization within to meet anticipated environmental needs. Even though the LHIN had emphasized the need for regional planning, the reluctance by hospital leaders and boards to reach beyond the confines of their hospital walls and coordinate patient activity put the leaders at risk for dissatisfaction by their funders. The new realities of integrated and community health had not percolated into the outlook of hospital leaders so that they realized the old way of doing things was not necessarily valid.

Although hospital leaders felt they worked in a turbulent environment, the future was mostly predictable. Changes within the Ontario health-care environment were stable, with 3-year budgets and a consistent population base. Hospital administrators were frustrated with the lack of communication by the LHIN and MOHLTC on what the provincial and regional strategies would be, although enough information was available for hospital leaders to examine how to improve organizational performance if they were aware of how the organization was performing. Because the strategic planning processes used by hospital leaders focused on the operational functions of the organization, hospital leaders could not strategically adapt to environmental conditions as they happened.

Resource allocation and internal direction. Focus group discussions revealed a conflict between physicians and nonclinical health leaders in the use of resources.

Administrators were responsible to the LHIN for providing financial accountability to the LHIN, whereas health-care professionals were responsible for achieving optimal health in their patients. Physician fee-for-service remuneration did not encourage physicians to manage their resource usage, and hospital leaders wanted to provide physicians the resources they required for patient care, but within fiscal limits.

With the dichotomy between the clinical and the nonclinical health leaders, and as focus group participants lamented the difficulty of drawing the health-care professionals into participating in the strategic planning process, the applicability of the strategic plan toward health-care professionals was questionable. An implementation plan might be realistic from the perspective of the administrator, but nonsensical to the health-care professional. Hospital administrators must develop collaborative relationships with health-care professionals to support cost-effective, evidence-based medicine (Hammarstedt & Bulger, 2006; Lefton, 2008) as well as encourage buy-in to the strategic plan. If the focus of the strategic plan for administrators continues to be finances without relating costs to physician behaviors, a power struggle over resource allocation and usage between the two groups will continue (Mohanis et al., 2005).

The conundrum of how to deal with resource allocation is a worldwide phenomenon. Recent researchers (Gross, Ashkenazi, Tabenkin, Porath, & Aviram, 2008; Hsu & Wu, 2009; Oddoye, Yaghoobi, Tamiz, Jones, & Schmidt, 2007; Okarafor & Thomas, 2007) all noted that increasingly older, sicker patient populations challenge the health-care system to provide more with less. Regardless of whether the health-care system is a single-payer system (Hsu & Wu; Oddoye et al.; Okarafor & Thomas) or managed care (Gross et al.), similarities exist for successful resource allocation systems:

data collection and evaluation on clinical services are necessary, a formalized implementation process designed to solve the resource problem is necessary, and reduction of fiscal burden by reducing human services through salary eliminations while providing short-term relief can increase the long-term cost to the system by increased length of stays and nosocomial morbidity (Gross et al.; Hsu & Wu; Oddoye et al.; Okarafor & Thomas).

Ontario hospital leaders who responded to the survey indicated organizational performance measures were underdeveloped and evaluation was inconsistent. The focus of most strategic plans was on operational issues and did not adequately address disease modalities, patient management, and resource allocation and use. Hospital administrators, like other managers, looked to reduce salary costs as a first step in fiscal management; nursing positions were one of the first job losses in hospitals (Hsu & Wu, 2009), although this type of fiscal behavior did not necessarily provide improved patient outcomes (McDermott & Stock, 2007). Hospital leaders participating in the study did not describe the allocation of resources by improving patient care as a priority.

Environmental uncertainty. While all focus group participants stated they believed they were working in a turbulent environment, they had a difficult time defining the term. To gain an understanding of what environmental changes constituted a turbulent environment, the participants were asked to provide examples. They isolated the new funding constraints and the role of the LHIN as the greatest sources of uncertainty. “They are tying strategies, are now mandated, and we need to perform, um, the way we are funded is different” (SMT01). While the nature of patient disease had not changed

substantially, the expectation of how hospital leaders conducted themselves within the Ontario health-care system had caused consternation among administrators.

Leaders use strategy to manage environmental change, and leaders exhibiting behaviors that lead change show strategic and transformational leadership. The comments made by focus group participants showed uncertainty in how to behave as strategic leaders. Although hospital leaders rejected the idea that LHIN administrators should provide direction on hospital strategy, there was reluctance among hospital leaders to become assertive in dealing with organizational and environmental change through strategy formation. The perception of environmental uncertainty might instead be a response to uncertainty of how to behave managerially to a restructured business format.

Research Question 3

What differences in strategic planning and views as best practices to achieve performance goals exist between types of hospitals (academic, community, or small)?

As expected, the leaders of small and community hospitals stated that they had a deficit in available staff or staff with expertise to do preparatory work for strategic planning. Small and community hospitals had smaller senior management teams, and the individuals on the teams assumed numerous portfolios within the hospital. There was also a large cost associated with the collection and evaluation of data, and small and community hospitals did not have the discretionary funds to complete the tasks (Hammarstedt & Bulger, 2006). Regardless of the hospital type, the focus group sessions demonstrated that all hospital leaders shared the same challenges when planning strategically, had the same knowledge deficiencies on strategic planning principles

(scanning, formation, and implementation), and had a collective lack of understanding in LHIN expectations of performance outcomes.

The results for this research question were surprising. There was an expectation that academic hospitals, with greater access to resources based upon the size of the organization and proximity to colleagues in the associated universities, would have significant differences from community and small hospitals. Although academic hospitals did identify staff to measure and monitor organizational performance, there was no difference from the other two hospital types in their ability to translate the resources into best practice methods. Although academic hospitals used the balance scorecard in greater proportion than did other hospitals (Yap et al., 2005), the Ontario Hospital Balanced Scorecard was primarily an external accountability report instead of a formative strategic tool (Parkinson et al., 2007). Thus, while some hospital leaders did have greater access to resources based upon the type of hospital, no significant difference in organizational performance existed between hospital types.

Quantitative (Phase 2)

The quantitative (P2) section of the study involved examining hospital leaders throughout Ontario to discover their perspectives on elements of strategic planning and included questions on how their hospital performed over the past fiscal year. The Likert-type survey contained questions on the construction of the strategic planning team, methods of managing the strategic plan, and perceptions of health-care leaders of the acute-care hospital environment. The predetermined indicators in the *Hospital Accountability Agreement* provided the organizational performance questions.

Research Question 4 and Hypotheses 2-3

What is the correlation, if any, between strategic planning and hospital performance in Ontario acute care hospitals?

H2₀: Hospital type (academic, community, and small) is not related to hospital performance.

H2: Hospital type (academic, community, and small) is related to hospital performance.

H3₀: There is a relationship between hospital performance and use of an identifiable strategic planning framework used by acute care hospital senior administration teams in Ontario.

H3: There is no relationship between hospital performance and use of an identifiable strategic planning framework used by acute care hospital senior administration teams in Ontario.

No significant results emerged from the analysis for Hypothesis 2; thus, the null hypothesis was not rejected. The large number of *do not know* answers for clinical indicators negated any potential discovery of whether hospital type had a relationship with organizational performance. Because the focus of acute-care strategic plans was on the financial standing of the organization, it was not surprising that hospital leaders were aware of their nursing status and current ratio, but not the readmission rates for chronic disease. The result that academic hospital leaders were as unaware of their organizational performance as were small and community hospital leaders was surprising. Because academic administrators stated on a more frequent basis they had sufficient human resources available to measure and evaluate data, it was expected that fewer *do not know*

answers would result. Response results from participants might be due to the following factors:

1. Financial data were current and monitored by a hospital senior leader.

Financial information was reported regularly to senior team leaders.

2. Organizational performance evaluation and measurement is expensive to produce. Budgets for small and community hospitals might not be sufficient to support collecting data for analysis.

3. There might not be individuals responsible for collecting and measuring data, or the individuals might not have appropriate training.

4. Hospital data are routinely three to six months behind in coding. Canadian Institute of Health Information receives all coding results and then displays the information on national databases. Recent data might not have been available to hospital leaders and they were waiting for the release of comprehensive results.

5. As indicated in participants' responses, performance measurement systems were underdeveloped.

6. Clinical performance measures might not be as important to hospital administrators as financial indicators, and therefore, allocation of resources to collect and analyze data was not as urgent.

The analysis for Hypothesis 3 followed Hypothesis 2; the *do not know* responses were dominant, and once removed from the data sets as missing information, the remaining sample size was quite small. The analysis identified one significant result: Factor 4—performance-based strategy pattern and diabetes. The significant result between diabetes and performance-based hospital leaders showed a response to the

emphasis that the LHIN had placed on diabetes disease management. A well-established diabetes protocol exists in the Ontario health-care system, and the MOHLTC (2008) had given a great deal of prominence toward the diagnosis and treatment of diabetes over other chronic diseases. Thus, the fact that leaders advocating a strategic planning pattern promoting identification of performance indicators that tied into the LHIN strategy had some knowledge on the organizational performance for this disease category was not surprising.

Regardless of these few significant results, the performance behaviors in the five strategic planning patterns were insignificant. Thus, the null for Hypothesis 3 was not rejected. The organizational performance characteristics of each pattern type were not conducive to consistent positive performance outcomes. Although some hospital leaders attempted to set targets and measure movement toward targets (Factor 1—LHIN focused), and other leaders used the LHIN/MOHLTC performance indicators as outlined in the *Hospital Accountability Agreement* (Factor 2—regional focused), the overall lack of knowledge on organizational performance inhibited the ability to influence change.

The failure to find a relationship between hospital strategy and performance outcomes speaks to the inability of leaders from all hospital types to understand how the organization performed in meeting the mission of the hospital, which was to provide excellent patient care. The data analysis indicated that the COO was quite often excluded from the strategic planning leadership. This might have occurred for two reasons. First, the COO position might not be well developed in smaller hospitals and several different hospital administrators shared this role. Second, the COO responsibilities might be viewed as falling into procurement, human resources, information technology, and other

functional areas that the hospital board does not view as strategic. Also reflected in the data analysis was that senior clinical leaders believed the health-care environment turbulence level was high or very high. The knowledge deficit of hospital administrators on clinical performance highlighted a disconnect between clinical outcomes and financial cost efficiencies. Without strategic importance placed upon clinical outcomes, and involvement by health-care professionals in the strategic planning process, it was difficult for hospital administrators to capture efficiencies within the operational management.

The organizational structure for acute-care hospitals falls into what Mintzberg (1993) called the “professional bureaucracy” (p. 200), where strategies are those of the various individual professions within the organization as well as influential external organizations. Ansoff (1957) noted that a strong distinction must be created between strategic management and operations management. As clinicians do not have a strong management background or the time to devote to hospital strategic development, the organizational strategies become those of nonclinicians who focus on operational initiatives and have greater presence within the upper echelons of senior management (Mintzberg, 1993). The basis of strategy is meeting the needs of customers (Porter, 1996), and operational effectiveness does not ensure that strategy is taking place. The strategy described by hospital leaders was nonstrategic, and strategic decisions were not applicable to the entire organization; strategy was limited to the bureaucracy of managing a hospital (Mintzberg, 1993). For hospital strategy to be successful, a blend of organizational components that support and reinforce the mission of the organization and result in effective strategic goals is necessary (Olson, Slater & Hult, 2005; Slater et al., 2006).

Clinical leaders had a greater knowledge base on how to treat patients, but might have felt unsecure about their knowledge on strategic planning and deferred to their management colleagues to lead them through the process. Health-care professionals who do not understand the rationale of the strategy developed by the senior management team can be a disruptive force within the organization and jeopardize any strategic success (Meyer & Tucker, 1992; Sorensen, Lloyd, Van Kemenade, & Harnett, 2005). Senior nonclinical management might have believed they had the expertise in strategic planning, but did not have the comprehension of what was necessary to provide patient care. If the balance of the strategic plan becomes financial and focuses on cutting costs without the measurements and knowledge of the effect on patient care, no benefit occurs to the hospital or the patients (Glouberman & Mintzberg, 2001b; McDermott & Stock, 2007).

What was missing from the strategic planning equation was collaboration, although this concept was pressed at hospital leaders from all ends. Collaboration is needed with health-care professionals so cost cutting does not result in reduced patient care (Glouberman & Mintzberg, 2001b; Khatri, Petroski, Halbesleben & Meyer, 2008; Lefton, 2008; Meyer & Tucker, 1992; Mohanis et al., 2005). Previous attempts at collaboration failed because the focus of the projects chosen was not on patient-care processes but on clinical support and administrative efficiencies; as a consequence, physicians did not see work processes designed to improve their professional responsibilities (G. R. Baker, 1994). G. R. Baker (2001) advocated the use of simple rules to decentralize decision making at the senior level. The development of simple rules would promote microsystems to restructure the practices of health-care practitioners, especially physicians, to coordinate the care of patients. This concept, while ideal, was

difficult to implement, as physicians were the least likely of health-care professionals to coordinate patient care in a team environment (Degeling & Carr, 2004). Hospital leaders approach restructuring of work processes within the hospitals with trepidation because of strong union resistance (S. Ho, Chan, & Kidwell, 1999).

The LHINs pressed collaboration between health-care providers in developing an integrated regional health-care system to promote a community health-care approach that would reduce replication of services, improve communication between health-care providers, enhance a multidisciplinary approach to chronic disease management, and increase accountability for patient care outcomes (Allen & Stevens, 2007; Banihashemi, Naeeni, & Aboutalebi, 2007; Ginn & Lee, 2006). The challenge for health-care leaders was that the business model they have worked under since the 1960s encouraged not a collaborative effort but a protectionist mind-set to maintain as many services as possible within the hospital. Hospital leaders were confused on how acute-care services meld into a community health-care approach.

The business format, strategic planning patterns, and performance methods employed by leaders of all hospital types were not successful in meeting required organizational goals as determined in the *Hospital Accountability Agreement*. Hospital leaders had a distinct lack of knowledge of how their organization performed in clinical areas. None of the strategic planning patterns applied by hospital leaders related to attaining performance goals. The conclusion drawn from the data analysis was that strategic planning had failed in acute-care hospitals in Ontario across all hospital types and strategic planning patterns.

Research Question 5 and Hypothesis 1

Which type of hospital performs better than others and which, if any, of the three strategic planning principles (environmental scanning, strategy formation, and implementation) are used?

H1₀: Hospital type (academic, community, and small) is not related to use of an identifiable strategic planning framework.

H1₁: Hospital type (academic, community, and small) is related to use of an identifiable strategic planning framework.

A purpose of the study was to determine if hospital administrators from different hospital types (academic, community, and small) gravitated towards using specific strategic planning patterns. Five distinct strategic planning patterns emerged from the analysis: LHIN focused, regional focused, independent, performance based, and team based. The patterns shared similarities, but each had specific differences in the priorities placed upon funders, internal stakeholders, and relationships with other health-care providers. The methodology used by hospital leaders when performing strategic planning under these patterns provided clues on why acute-care hospital leaders found strategic planning did not meet their expected goals.

LHIN focused. The organizational structure for this planning pattern was a blend of competitive and financial (Topping & Hernandez, 1991), where hospital leaders had a concern about differentiating their hospital services from other regional hospitals. Financial allocation of resources was the primary driver of the strategic plan. Hospital leaders were conscious about using regional LHIN strategy when developing strategic directions for their hospital. Outside funding bodies had a great deal of influence in the

direction of the strategic plan; the informality of developing the strategic plan allowed the LHIN strategy to carry more weight than other strategic planning patterns. Environmental scanning activities were not formalized routines and there were more strategic initiatives than could be successfully completed during the life of the strategic plan. Implementation of the plan received little consideration.

The strategic pattern described as LHIN focused followed the strategic theory of resource dependency closely (Pfeffer & Salancik, 2003). An interlinking existed between LHIN administration expectations of hospital strategy and hospital leaders' development of strategic goals. Whether the power relationship between the LHIN-focused hospital leaders and the LHIN administration increased the ability of the LHIN to coerce actions not otherwise taken by hospital leaders remained unknown (Palmer, 1983; Stigler, 1971). Instead, it might be that some relinquishment of the independent development of strategic goals occurred and goals met LHIN's predetermined requirements. One behavior of independent strategy was that LHIN-focused hospital leaders strived to differentiate their hospital from other regional hospitals to preserve current hospital services.

Effectiveness of resource utilization is an expectation of external groups in resource dependency (Pfeffer & Salancik, 2003). For effective resource utilization, hospital leaders must have an awareness of internal and external environmental influences to demonstrate an enacted environment (Weick, 1979). While LHIN-focused organizational leaders increased environmental scanning activities, this action was not consistent. Thus, hospital leaders were vulnerable to responding to changing environments or expectations in behavior. Interdependencies between the hospital leaders

and the LHIN led to conflict on resource allocation, which created an uncertainty that hospital leaders described as environmental turbulence (Pfeffer & Salancik).

As the focus of strategic development by the LHIN was on theoretical applications of community and acute-care health-care blending, hospital leaders attempted to adopt the concepts and resulted with a disconnect between the administrative work and distributing the legitimacy of the new model to the health-care professionals within the hospital. This disconnect could have ramifications upon the recruitment and retention of hospital staff. As hospital leaders were leaning toward the LHIN for justification of their behaviors, little emphasis existed on the development of organizational performance measures.

Regional focused. The organizational structure for this strategic planning pattern was cooperative (Topping & Hernandez, 1991). To better utilize scarce resources, the hospital leaders believed that different hospitals should provide somewhat different patient services. The development of strategic goals, while primarily operational, did include a consideration of clinical needs. A high priority for this group of administrators was developing the hospital strategic plan to align with the LHIN regional health-care vision.

Some degree of overlap of strategic goals occurred from plan to plan, and when changes did occur in the health-care environment, the tactics of the goal changed rather than the orientation of the strategy itself. Little scanning occurred despite hospital leaders accepting the LHIN expectation of developing health-care delivery on a regional approach. The behaviors resulted in a strategy that did not fit the health-care environment hospital leaders worked in. A greater cognition of clinical needs from the physicians'

perspective led to improved ability of gaining participation from health-care professionals when implementing the strategic plan.

The pattern that regional-focused hospital leaders displayed linked with Miles and Snow's (2003) emerging strategic plan of the matrix organization. This adaptive pattern attempts to merge the needs of stakeholders in previously established relationships and the LHIN in the new relationship of community engagement (Allen & Stevens, 2007; Olden & Smith, 2008). Joint planning on a regional basis involved looking to regional partners and the LHIN to determine how the coordination of patient services took place. To develop new strategies to achieve goals, a requirement to change organizational culture or operations often exists (Pleshko & Heiens, 2008). It is not certain whether hospital leaders were willing or able to take these steps.

That these leaders agreed that some hospitals provided different patient services through a regional perspective exhibits Ansoff's (1957) concepts of developing new products within existing markets. Within the Ontario health-care system, an opportunity exists to market hospital competencies and skills through a strategic marketing process (Pleshko & Heiens, 2008). As Miles and Snow (2003) indicated in their germinal work, this process was difficult; inclusion of clinical and operational models was necessary to meet the needs of all stakeholders. Divergence and conflict occurred between LHIN, health-care professionals, and other health-care organizations on the development of regional health-care strategy.

Independent. This strategic planning pattern did not incorporate any of Topping and Hernandez's (1991) organizational structures, nor did it display any overt influence by either hospital professional staff or outside funding bodies. Instead, the focus of the

planning pattern was on the actions and beliefs of the senior team. Greater delegation of strategic planning responsibilities to middle managers, and little in the way of formalized implementation plans, occurred within the hospital. The senior team, while cognizant of internal competencies and skills, did not place a great deal of emphasis on external scanning. The statistical significance between small hospitals and the independent strategic planning pattern was due to the inaccessibility of administrators of small hospitals to staff assigned to implement the strategic plan or have staff with evaluation and measurement expertise. Due to the lack of evaluation proficiency, small hospitals were deficient in creating financial and clinical measurement systems. Organizational performance systems designed for financial and clinical KPIs existed; yet an expectation existed that managers would develop their own tactical plans to implement the strategic plan. The focus of the hospital administrators was on what was happening within their organization.

Many elements of the design school of strategic planning resonated with the independent pattern. Strategy formation was a deliberate process, the responsibility of the strategy development rested with the senior team, and the model of strategy formation was simple and individualized for the hospital (Mintzberg et al., 1998). Detractions from using this form of strategic planning existed. The lack of external review by hospital leaders negated the concept that strategy development determined how the organization would engage the environment (Hambrick & Fredrickson, 2005). The inward focused organization did not incorporate learning into strategy formation (Jha-Thakur, Gazzola, Peel, Fischer, & Kidd, 2009), putting hospital leaders at risk for repeating the same strategic planning errors. Hospital leaders using the independent pattern did not separate

strategy formation from implementation (Mintzberg et al., 1998) by assuming middle managers had enough understanding of the strategic plan to sell it to their staff and implement it in their functional areas.

By isolating the vision of the strategic plan within the confines of what was happening within the organization, the hospital leaders became vulnerable to changes within the health-care environment. The lack of external review eliminated the ability of independent pattern administrators to incorporate into the hospital strategy LHIN-driven performance expectations. Such an inclusive stance, while protecting organizational autonomy, juxtaposed the new collaborative approach that the MOHLTC was promoting in acute and community health care.

Performance based. Hospital leaders who practiced the performance-based strategic planning pattern felt that this mind-set was new in the Ontario health-care environment. The performance-based pattern demonstrated financial organizational structure (Topping & Hernandez, 1991), where functional areas' strategic initiatives supported organizational strategy. Although the hospital leaders created performance indicators based in large part on LHIN requirements, administrators separated hospital strategy from LHIN strategic expectations. Hospital leaders examined other health-care organizations' inventories of patient services before determining their own strategic goals and relied upon external sources to provide environmental scanning information. Implementation of the strategic plan rested primarily on a designated individual whose responsibility it was to monitor the achievement of strategic initiatives.

One of the challenges of planning as described by Mintzberg (1994) is “performance control” (p. 78), where strategy is routine, quantitative in nature, and

geared toward negotiating a set of expectations. If, as hospital leaders stated, Performance-based strategic planning patterns were a relatively new mind-set in the Ontario acute-care environment, the characteristics of this strategy pattern might be underdeveloped and will see growth in future years. The business model of performance accountability that the MOHLTC and LHIN had introduced in the past three years might have driven hospital leaders to look for a strategic planning theory to provide direction on how to meet these new measurement expectations. A standard methodology that over the years many managers have attached to was Porter's (1996) positioning theory.

To maximize resources, performance-based hospital leaders determined their hospital strategies after examining the behavior and performance of other regional health-care providers. Hospital leaders recognized the importance of determining organizational performance as measured by LHIN clinical indicators, and established targets and measurements toward these LHIN indicators. The hospital administrators responded to the expectations of accountability for both financial expenditures and hospital performance by finding methods to perform differently than their regional counterparts. However, a disconnect occurred when aligning strategies to meet LHIN expectations and separating hospital strategic goals.

Porter (1996) warned that strategic positioning requires trade-offs within the ability of an organization to reposition itself within the industry. In the case of Ontario hospital leaders, the risk came when determining the positioning of patient services and health-care professionals' responses to the organizational decisions. Academic hospitals were more flexible in this type of strategic positioning as these organizations provided care by specialists. Community and small hospitals were less flexible in restricting

patient services due to pressure by community stakeholders. Stakeholders influenced the resulting dual strategic goals, hospital and LHIN as described by hospital leaders, to maintain as many services as possible. Porter contended that successful strategies recognize trade-offs and accept that an organization cannot be all things to all stakeholders. The risk of using separate strategies to satisfy all stakeholders was that instead of an efficient use of scarce resources, the conflicting stakeholder demands overtaxed the hospital leaders' ability to satisfy everyone, and organizational performance suffered across all levels.

Team based. The team-based strategic planning pattern found hospital leaders using external and internal stakeholders' clinical needs to determine hospital strategy. While the organizational structure of the planning pattern was corporate (Topping & Hernandez, 1991), hospital leaders consulted with their regional colleagues to determine the coordination of patient-care services. Front-line physicians and nurses are valued partners at the strategy planning process. It is important to the hospital leaders to have teams or task forces of health-care professionals and community partners assist in determining strategic goals. The focus was on internal and community stakeholders when developing strategy; expectations of the LHIN received little attention.

When financial resources permitted, the leaders attempted to provide staff access to clinical education programs to meet organizational goals. When finances and staff expertise allowed, an individual was responsible for gathering information on population health needs in their communities. Despite the efforts in gathering information and soliciting input from organizational partners, the hospital leaders were deficient in creating an implementation plan for the strategy.

The strategic planning theory most aligned to team-focused pattern was resource allocation. As in the team-focused pattern, external influences had reduced influence upon the allocation of resources, and the drivers of the strategic plan were internal stakeholders and groups who were considered important to the development of the strategy (Noda & Bower, 1996). The involvement of the health-care professional staff motivated the strategic plan to drive specific resource allocations based upon individual medical staff priorities. While the resource allocation strategy might have had a higher success of gaining active participation by health-care professionals in the development of the strategic plan, consequences to hospital strategy existed. Physician professional requirements of standardized patient care drove budget allocations that were not necessarily efficient or effective for the organization as a whole (Lefton, 2008).

The exclusion of LHIN strategies directed the hospital vision toward health-care professionals' ideals and not necessarily the realities of a fiscally constrained acute-care environment. Acute-care physicians under the current payment schedule showed interest in maintaining their current financial status and were not as amenable to developing new health-care system deliveries (Olden & Smith, 2008). Although hospital leaders who used the team-based strategy pattern consulted with their regional colleagues, the methodologies found in resource allocation were not conducive to creating a regionally based health-care strategy.

An examination into the results of organizational performance against the five strategic planning patterns indicated no correlations between strategic planning and performance. The five strategic planning patterns, while providing insights on actions hospital leaders took to develop a strategic plan, contained no demonstrative strategic

planning structure that translated into successful performance outcomes. The data analysis indicated that hospital leaders were devoid of formalized strategic planning methods and had little knowledge of their organizational clinical performance. Only 70% of hospital leaders stated that they were taking specific actions to relate hospital outcomes to required LHIN performance targets.

While hospital leaders had better understanding of their financial performance and outcomes, they were unaware of their clinical performance. The lack of awareness on clinical outcomes may be due to the high cost of tracking and evaluating patient cases, or it may be due to the emphasis placed upon operational goals of the hospital administration. The behaviors of hospital administrators demonstrated a lack of strategic leadership resulting in missed opportunities to improve not only patient care delivery, but also increased cost efficiencies.

The lack of formalized strategic planning structures severely hampered the effectiveness of the organization to meet environmental changes. An immense knowledge gap existed between the community health strategy promoted by the LHIN and MOHLTC and acute-care hospital administrators. The insular and protectionist behaviors of some hospital leaders further decreased the ability of administrators to create strategic plans that met the requirements of the LHIN health-care system. The lack of knowledge of organizational performance and the inability of hospital leaders to respond to negative outcomes by adjusting organizational structure and management led the LHIN and MOHLTC to make further health-care reforms and follow other provinces to move the control of hospitals under regional authorities. Finally, lack of strategic leadership by hospital administrators placed at risk the hospital mission of providing patient care.

Due to the lack of statistical significance, the null hypothesis was not rejected.

The lack of significance differences may be attributable to several reasons:

1. As discovered during the qualitative and factor analyses, no systemic method or approach to strategic planning existed, regardless of hospital type. Although factor analyses generated five relatively distinct strategy patterns, the patterns might have been insufficiently distinct and coherent.

2. None of the hospital leaders had developed an effective scanning system to ensure the strategy they created had the ability to be effective in meeting clinical and financial expectations.

3. The formulation of hospital strategy centered on operational goals, which, while meeting organizational needs, were not strategic approaches that assisted hospital leaders with meeting challenges in the new LHIN health-care environment.

4. A comprehensive implementation structure for the strategic plan was not found in any of the hospital types.

5. None of the hospital leaders had developed an effective measurement system to determine the progress of strategic goals.

As the strategic plans throughout the Ontario health-care industry were informal and inconsistent, no strategic framework was identifiable. Only Factor 3 (independent pattern) had some relationship to small hospitals, but this relationship underlined the lack of resources available to administrators of small hospitals, contributing to their inability to implement strategic planning principles. The lack of strategic frameworks for any hospital type raised a concern that despite some hospitals having access to strategic expertise, a lack of knowledge on effective strategic planning exists in the acute-care

system. As the LHIN expectations of hospital interorganizational relationships were changing, without a comprehensive understanding of strategic planning and implementation, hospital administrators had a difficult time adopting and adapting their organizational structures to meet the new demands.

The development of functional area tactical plans to match organizational strategic goals was new behavior for hospital leaders. Due to financial abilities, significant differences existed in hospital types to develop and evaluate performance outcomes. Hospital leaders were not flexible in that they did not have the will, or perhaps the training, to develop alternative strategies that accommodated the new LHIN environment. Strategic leadership by hospital leaders was not consistent, leading to difficulties during the implementation process and lack of buy-in by organizational stakeholders.

The data analysis indicated that all hospital types were in the same situation in that performance outcomes are below the expected ranges as predetermined by the LHIN. This indication was surprising, as an expectation existed that academic hospital leaders had a greater ability to strategically plan, evaluate, and measure their organization's performance because they had enhanced levels of human resources. Unfortunately, the data showed that academic hospitals fared no better than did small and community hospitals.

The new vision promoted in health-care policy in Ontario requires acute-care hospital leadership to think beyond the old way of doing business. The organizational structure of acute-care institutions might not be amenable to the new vision of health-care delivery as directed by the regional LHINs. Strategic planning methods that resulted in

the recent health-care reforms did not allow acute-care hospital leaders to maneuver their organizations into a new way of integrated regional health care.

Summary of Major Findings

The study had two purposes. The first was to understand whether acute care hospital administrators in Ontario used strategic planning, and, if so, how administrators used it. The second purpose was to explore relationships between strategy, hospital type, and organizational performance at the acute-care hospital level. Analyses of qualitative and quantitative data indicated that acute-care hospital leaders in Ontario had no formalized strategic planning structures. The study involved identifying five strategic planning patterns, although each planning method showed inconsistent and incomplete usage of standard strategic planning principles of scanning, formation, and implementation. As a result, none of the five planning patterns related to organizational performance. Hospital administrators, while knowledgeable about their organizational financial performance, overwhelmingly did not know the clinical outcomes of their chronic disease patients. Thus, no significant results existed between strategy pattern, hospital type, and organizational performance.

The inconsistent performance by acute-care hospital leaders in Ontario not only detracts from providing excellent patient care and cost efficiencies, but also places the industry at risk for further regulatory reforms by the MOHLTC. The most recent health-care reform, introduction of the LHIN, was designed to improve integrated regional health care and promote collaboration and cost reductions within the health-care system. Hospital leaders and boards risk losing their autonomy if they are unable to resonate with this direction and develop strategies to orient their organization to accommodate the new

vision of health-care delivery in Ontario. While individualized for each hospital, every strategic plan had specific commonalities. The recommendations that follow are for acute-care hospital leaders on a system basis. Some recommendations refer to how the OHA can assist their member hospitals to improve strategic planning.

Study Limitations

The study had several limitations. First, the willingness of hospital administrators to share openly their perceptions on strategic planning was important for the validity of the survey. The focus group participants were quite forthcoming about their approach to strategic planning and, more important, the areas they felt they were deficient. The survey respondents provided numerous comments on why they took the actions they did when planning strategically. Many noted that they as senior leaders did not perform as consistently as they could have during the strategic planning process.

Second, the survey was limited to senior administrators, and the exclusion of other managers within the hospital environment could have restricted the understanding of the complexity of strategic planning within the hospital type. As middle managers and clinical leaders are often the implementers of the strategic plan, feedback from these individuals might provide a richer context of the success or failure of strategic plan implementation. This limitation was acceptable for the study, as it was important to understand if the senior team responsible for strategic planning had the necessary skills to direct the implementation process. Understanding the complexities of implementation from the perspective of clinical leaders would be an area for future research.

A third limitation was that the qualitative phase of the study was limited to southern Ontario, and the information gathered might not reflect the different resource

needs and capabilities of hospitals in other geographic locations. A review of the data analysis showed no differentiation between hospital geographic location and hospital strategic planning behaviors. Thus, the data did not appear to be skewed to reflect a bias toward hospital leader behavior in one section of the province.

Fourth, the study was cross-sectional and not longitudinal. Due to changes in hospital funding structures since 2007, examining current organizational performance, and not the overall behavior of hospital administration teams over several years, was important. An area for further research would be to follow hospital strategic planning processes and the outcome of those strategic plans over time to determine if hospital leaders are able to develop successful strategic plans within the new LHIN environment.

A limitation noted at the beginning of the study was that using qualitative thematic content to develop quantitative survey questions could miss significant components of administrators' strategic planning. The limitation was minimized in that the survey developed used foundational strategic planning theory, relied upon responses grounded in a representative setting, and was reviewed by an expert panel and piloted by hospital leaders. Integrating the data gathered from both the P1 and P2 portions of the study reduced different interpretations of specific concepts on multiple levels so that a consistent view of hospital leaders' perceptions emerged.

If only certain types of hospitals responded to the survey, the results would skew the data and in turn, affect the ability to obtain accurate data on a provincial basis. A review of the geographic locations of survey respondents showed adequate representation from all areas of the province. Thus, generalizations on hospital leaders' strategic planning behaviors were reasonably valid.

The P2 portion of the study was delayed for several months over the summer to gain as many respondents as possible. Limitations discovered during the survey run were the lack of access to e-mail addresses of hospital administrators, resulting in letters mailed to hospital leadership teams. Distribution for the Web-based survey involved a reliance upon CEO administrative assistants sending an e-mail to obtain the Web survey address electronically. Without the e-mail-based hyperlink, senior administration teams were unable to gain access to the survey.

Although the survey was sent out in the fall, administrative assistants sent e-mails indicating that some CEOs, who would be the person to determine if the survey would be distributed to senior leadership, were on vacation. The administrative assistants of CEOs sent several e-mails detailing why their leaders were unable to participate in the survey. Responses included the leaders were involved in restructuring hospital activities to meet the requirements of the LHIN, the leaders were grappling with budget matters that fell short of financial requirements, and the questions were too complex for the administrators to answer. One hospital leader wanted the research study to undergo her hospital ethics process before she would participate in the survey.

Significant limitations to the validity of the survey results were a consequence of the vast number of do-not-know answers when participants were asked about their hospital performance. Because the responses were classified as missing data, out of the six performance measurement questions, three had almost 60% do-not-know responses and one had 67% do-not-know responses. The apparent focus upon financial and operational goals by hospital leaders in lieu of strategic concerns had repercussions in that hospital leaders were not focusing on the core purpose of the hospital, which was to

provide patient care. The lack of analysis at the care delivery level means missed opportunities to identify cost efficiencies as well as improve patient care delivery (Allen & Stevens, 2007; Sorensen et al., 2005). These responses resulted in reducing the sample to undergo statistical analysis. While a glimpse of positive relationships resulted from the examination of organizational performance in relation to hospital type and strategic planning patterns, the result was not generalizable due to the small sample size. The fact that results were unable to undergo proper analysis due to the large amount of missing data was significant.

Implications and Recommendations

The MOHLTC, LHIN administrators, and OHA directors all play a role in developing Ontario health care policy and administration of such policies within the acute care hospital industry. The implication of the lack of effective strategic planning and recommendations to improve strategic planning within hospitals is discussed.

Recommendations for Research

The purpose of the research was to determine whether hospital leaders used strategic planning, and if so, whether the strategic planning resulted in positive organizational performance outcomes. The present study was the first research to involve examining the strategic planning behaviors of Ontario acute-care hospital leaders. The new model of blending community and acute health care requires different concepts of what an acute-care hospital is. It remains unknown if the current business model and organizational structures are able to accommodate the legitimate purpose of and the corresponding vision for Ontario acute-care hospitals; quality health care in the quantity needed for patients.

Not only was the focus of community health ambiguous to hospital leaders, but the structural format of the hospital was not designed to monitor patients before or after leaving hospital. Although hospital staff exists to coordinate patient discharge from hospital, it is uncertain how many hospitals have dedicated staff to coordinate community health care and acute-care patient services such as outpatient clinics, urgent care, maternal–child, or chronic disease. Further research is necessary on acute-care hospital organizational design, necessary management structure within an integrated health-care system, and the effect on strategic planning.

The structuralization of strategic planning in the five patterns raised questions of how managerial behavior drove the differentiations. The theoretical foundations in this study used the strategic theories of resource allocation and resource dependency as models of intended, emergent, and imposed strategy. The results indicate that hospital leaders were starting to introduce concepts of differentiation and to develop and implement measurement models. The study was not designed to examine the leadership and training of hospital leaders that caused them to prefer one method of strategic planning to another. Still successful strategic planning requires strategic leadership (Ireland & Hitt, 1999/2005).

A case study with one or two hospitals to examine their strategic planning process would identify organizational structures that assist or hinder the ability to meet LHIN expectations of organizational performance. The leadership assessment would also involve evaluating differences between hospital leaders who have an interest in moving their strategic plans to accommodate LHIN strategy and hospital leaders who are protectionist and unwilling to accommodate the new health-care policies. Longitudinal

research on any changes made to organization, management, or strategic processes would determine if an effect occurred or did not occur on performance outcomes.

Implications for Policy Makers

The LHINs were legislated into being as a method of increasing the accountability of hospital leaders and boards to the MOHLTC on the spending of health-care dollars, while also ensuring that patients requiring care received needed services in a timely fashion. In the interest of finding quick fixes to the health-care spending spiral, the MOHLTC brought another level of bureaucracy into the mix without ensuring that all the players in the Ontario health-care environment understood what the end results were to be. The result is mass confusion on the LHINs' role in providing acute hospital care beyond an assigned budget and vague organizational performance goals. The MOHLTC implemented a new business vision of delivering health care, but did not contemplate whether hospital leaders understood that the methods used for decades in providing acute care were no longer viable. As well, no evidence indicates that any discussions were ever organized between all of the stakeholders in the acute-care setting on how health-care organizations would have to change to meet the new care delivery system.

The LHINs have become a version of the overbearing parent. Hospital leaders and boards receive a budget and direction of services to provide, but LHIN administrators want to have veto power over any strategic direction that hospital leaders wish to use when implementing the new directions. It will become difficult to determine the reasoning behind the strategic planning purpose for hospitals if the LHINs continue to micromanage much of the strategic initiatives that hospital leaders and boards wish to implement. It is also difficult for hospital leaders to develop strategic planning in this

environment as increasingly, their hands are being tied behind their backs. The LHINs were developed to be the overseers due to the mismanagement of past hospital administrations, and the role that the LHIN now plays is to coerce health-care leaders into collaboration and consolidation of services. Like parents who tell their children what to do but do not teach them how to do it, hospital administrations will continue to be unsuccessful in changing their ability to meet performance expectations if they do not receive the proper tools.

In researching for the study and noting the pattern of health care reform over the past 15 years, the MOHLTC put a great deal of effort into the development of health-care policy change to improve the fiscal and patient-care delivery of acute-care services in the province. Like their hospital administration colleagues, the MOHLTC did not put in a great deal of effort into developing a successful implementation plan. There was no assurance that hospital leaders understood, or were prepared, for the policy changes brought into legislation. Few communication strategies exist with hospital leaders except for those that each LHIN develops and through the OHA.

When discussing Ontario health-care policy with the MOHLTC, the OHA acts as a voice for hospitals. In addition to advocating for hospitals at the government level, the OHA provides its members with numerous workshops, seminars, and leadership courses to enhance management within hospitals. The OHA has resources that can provide additional information and guidance to members to improve the strategic planning process. The OHA can also advocate to the MOHLTC and LHINs for resources to improve the ability of hospital leaders to measure organizational performance and evaluate outcomes.

Recommendations for Policy Makers

The following recommendations are on a system-wide basis. The OHA has a role to play in representing hospitals at Queen's Park and then serves as a distribution channel to hospital senior teams. The MOHLTC creates the policy that the LHINs then implement. Without the MOHLTC taking an active role in the distribution of information to hospital administrations, the potential exists that hospital leaders in different LHINs have different understandings of the overall provincial health-care strategy, much less a regional approach. A concentrated effort on a system-wide basis would be necessary to develop a comprehensive strategy that all hospital administrations can partake in to meet health needs not only in their community but also on a regional and provincial basis.

Develop Health-Care Planning Modules

During the research process, the refrains from hospital leaders were constant in that they did not have a clear understanding of LHIN terminology such as community engagement or the definition of health-care integration. The new health-care delivery models created by the MOHLTC through the introduction of the LHINs were foreign to the acute-care process. Further instruction of the concepts and tools to integrate the models into the culture of acute-care health care is critical for acute-care strategic plans to reflect the overall community-based direction as determined in the new MOHLTC strategy.

The MOHLTC created *The Health Planner's Tool Kit* (Ardal, Butler, & Edwards, 2006; Ardal, Butler, Edwards, and Lawrie, et al., 2006a, 2006b, 2006c, 2007; Ardal et al., 2008) as resources for LHIN administrators as they developed and implemented their community-based strategies. Modules that bridge the LHIN strategic vision into an acute-

care environment would improve communication strategies between hospital administrators and LHIN leadership. Hospital teams would receive greater understanding of LHIN terminology and obtain a foundational level of what integrated health care is, what it looks like, and steps to begin the process. The modules would provide methodologies to integrate those strategic planning practices into the hospital strategic plan.

Implementation of the modules could take place through didactic presentations, Web seminars, and e-learning formats. The critical component of developing these modules is for all hospital administrators to have the same understanding of what the expectations are from the MOHLTC in developing regional and community health-care approaches. Use of a systematic learning presentation can be distributed throughout the middle-management levels so that hospital administrators provide learning opportunities to hospital stakeholders and increase the buy-in to the strategic vision.

OHA Provision of Strategic Planning Resources

Hospital leaders were overwhelmed with the day-to-day portfolio of administrating acute-care services in their respective communities. Health-care providers focused on delivering patient care with the resources available to them. Hospital boards included community members who value the health-care services provided by their local hospital; however, the vast majority of hospital board members had never worked in the acute-care environment. What resulted is a situation S. Glouberman described as “there is no one in a hospital who fully understands what it is to deliver healthcare in a hospital” (personal communication, October 16, 2006). Further development of strategic leadership in the senior teams is necessary.

The Ontario health-care environment made considerable changes with the introduction of the LHINs. Yet most hospital organizations did not have access to individuals with strategic planning expertise to assist them in navigating the changes. The OHA could assist their member organizations by providing access to individuals with strategic planning expertise. The resource individuals could assist hospital leaders and boards to dissect their strategic plan and provide tools that improve their strategic planning and organizational performance outcomes. The business model that LHIN health care is now expecting is unfamiliar to hospital leaders, who might require some assistance to meld the old way of providing local community health care with the new way of providing regionally integrated health care. The resource individuals could come from diverse fields: management and organizational change, finance, physician, and nursing backgrounds. By providing a wealth of interdisciplinary resources, there is an increased likelihood of the strategic plan meeting LHIN leadership expectations, clinical needs, enhanced clinical and cost efficiencies, and improved buy-in by hospital members.

Measurement Models and Key Performance Indicators

The research results showed that hospital leaders were overwhelmingly unaware of their hospital performance. Collecting and evaluating data at the hospital level is expensive and requires individuals with expertise. Hospital administrators rely upon CIHI and other metrics to provide data on clinical behaviors. Unfortunately, the data are significantly out of date by the time that hospital leaders receive the results. Because hospital data are not timely, it is difficult for hospital leaders to tie organizational performance results to specific behaviors or trend data to measure responses to change in patient-care delivery. Hospital leaders were unable to modify strategic plans or

operational goals designed to meet strategic goals quickly so that results were positive and responsive to LHIN expectations.

Although available for many years, adopting various balanced scorecards and metrics designed for acute-care hospital leaders' use was unsuccessful (Yap et al., 2005). For a variety of reasons, hospital leaders were unwilling or unable to use such tools to assist in strategic planning and measuring of strategic initiatives. Administrators at OHA, MOHLTC, and LHINs need to examine what is necessary for improved real-time data collection methods and measurement models. Without accurate knowledge of recent organizational performance, hospital leaders are unaware whether current strategic models are effective or ineffective. The ensuing result is that LHIN and MOHLTC administrators are unsatisfied with the steps taken by the hospital leadership to resolve organizational performance issues. Chronic disease readmissions not only affect acute care resource needs such as lengths of stay and nursing care time, but also highlight whether community-care availability is sufficient to prevent the patient populations from returning to the hospital. As the LHINs and MOHLTC continue to thrust integrative care models into the acute-care setting, it is important for hospital administrators to have at their disposal information that measures acute-care health-care outcomes and that indicates where failings in the system exist, preventing hospitals from meeting expected targets.

Assistance from the MOHLTC in the provision of funds for the development of measurement software, especially for small and community hospitals, is necessary so that hospital leaders at all levels have an accurate reflection of clinical outcomes. The MOHLTC and OHA in collaboration can provide training sessions to key hospital

personnel on the development of measurement models and methods of data collection. Manuals of how to interpret data results and using data analysis in the development of strategic planning, clinical evaluations, and cost analysis would be beneficial to hospital leaders and staff to promote accountability and action within hospital organizations.

Recommendations for Hospital Administration

Leaders use strategic planning to position their organization within the industry and environment, ensuring its successful future. The results of the study showed that Ontario acute-care hospital leaders have a poor grasp on strategic planning principles and how to best use those principles to maneuver their organization to meet funder and community expectations when delivering patient care. Hospital leaders have a range of conflicting priorities and the inability to organize these priorities in relation to the expectations of the LHINs. Implications of the inconsistent strategic planning and lack of strategic leadership have resulted in several recommendations.

Hospital Evaluation of Strategic Planning Framework

Making effective change to a strategic plan is impossible if there is no awareness of what requires change. Hospital leaders and boards should undertake an evaluation of the strengths and weaknesses of their strategic plan and the processes they use to create the plan. Determining what form of strategic plan framework they apply as an organization highlights deficiencies in the use of strategic planning principles. Relating the type of strategic plan used to strategic planning characteristics needed for organizational performance success should improve organizational outcomes.

Hospital leaders must take steps to formalize processes such as environmental scanning, strategy formation, and implementation. A regular review process of the

strategic plan is critical to compare targets against progress made in achieving goals. The senior team members with their managerial staff need to develop measurement methodologies that are part of the strategic review process. The previous method of checking off boxes is not sufficient to ensure strategic and organizational success.

Using expertise provided by the OHA, hospital leaders and boards would review the strengths and weaknesses of their strategic plans and determine which strategic planning principles are deficient. Strategic experts at the OHA would be available to hospital leaders and boards throughout the strategic planning process, as well as plan reviews. Strategic planning experts from a variety of disciplines would help hospital leaders to create implementation programs that are relevant to all hospital and community stakeholders.

Development of Strategic, Not Operational, Goals

Throughout the research a great deal of confusion existed regarding which strategic goals were compared with strategic initiatives and how to develop tasks to achieve initiatives. Hospital administrators confused operational goals with strategic goals. Although operational goals assist in improving the internal workings of the hospital, operational goals do not move the organization forward in setting new strategic expectations or standards. Administrators are encouraged to evaluate what is occurring within internal and external environments of the hospital to better understand what goals are necessary for strategic development and how to align goals. As discussed earlier, utilizing OHA strategic planning experts would assist hospital leaders and boards to create goals that move the organization toward the mission and vision statements.

Regional Meetings With OHA, LHIN, and MOHLTC

Hospital leaders consistently stated they did not understand community engagement and regional integrated health care. Regional meetings are required with community health-care leaders, hospital teams, and representatives of the OHA, LHINs, and MOHLTC to gain an understanding of what is necessary to create a community health-care system. Hospital leaders need to evaluate how a regional system fits into their own organization and then appraise their hospital management and organizational structure to determine what changes, if any, are necessary to adapt to this form of health-care system. The previous health-care delivery models in Ontario have changed, yet the management and patient-care delivery systems have not. Without developing an understanding of what change is necessary to implement this form of community-care delivery, hospital leaders will continue to have unsatisfactory performance outcomes.

Using a workshop format, regional health-care leaders would be able to utilize strategic planning principles of scanning, formation, and implementation to create realistic and cost-effective health-care programs. Health-care providers would be able to compare competencies and skill sets to determine how to merge health-care delivery within a regional context. After developing a regional delivery system, hospital leaders would take this information to their respective organizations to use in their own hospital strategic planning process.

Development of Measures, Targets, and Evaluative Systems

Developing large, hospital-wide measurement scales is difficult and, for many hospitals, cost prohibitive. Smaller micro-measurement models that involve examining performance on a functional or patient unit area are reasonable and more effective to

implement. Relevant linkages exist between clinical performance and cost-effectiveness in hospitals. The data analysis in the study revealed that hospital administrators have a deficit of knowledge of clinical outcomes. Hospital leaders need to complete an evaluation of clinical outcomes and the impact on organizational effectiveness.

The creation of clinical and administrative groups to develop clinical evaluative processes will assist to standardize practices, ensure the implementation of evidence-based best practices, identify areas of cost efficiencies, and improve patient care. These measurement models, when attached to functional or unit tactical plans, help to identify clinical outcomes, cost effectiveness, and efficiencies on an individual unit level and assist the area managers and their staff to determine how they are helping to meet organizational strategic goals. The micro-measurement goals provide accountability to individual hospital areas and, when tied to LHIN clinical performance expectations, help clinical leaders to understand how they might need to modify their strategic initiatives to meet changing environmental conditions.

By asking health-care professionals for their ideas on how to implement evidence-based practices that result in not only improved patient care but also improved efficiencies in the professional's ability to provide care, hospital leaders will not only develop organizational buy-in but harness cost reductions. Examination of practices on patient units will identify lack of organizational standardizations and inefficiencies in work processes, material usage, and staff usage. Such information contributes to the strategic plan for both financial and clinical outcomes, as well as helps to determine which strategic initiatives hospital leaders require to create or meet strategic goals.

Summary and Conclusions

The mixed-method study involved an exploration into strategic planning in the perspective of Ontario acute-care hospital leaders and the influence, if any, of strategic planning and hospital type on organizational performance. In 2006, the MOHLTC introduced new legislation that created the regional LHINs. Acute-care hospital leaders received new accountability and organizational performance expectations. Reoccurring health-care reforms had not achieved the level of success desired by the Ontario government in creating efficiencies that saved dollars spent on health care. The latest health-care reform introduced a new business model into the Ontario health-care environment. The analysis in the study led to a determination that acute-care hospital leaders in Ontario are unprepared to strategically plan within the new environment.

While hospital leaders thought they were performing adequate strategic planning, upon reflection and examination a different reality emerged. Hospital administrators readily admitted that strategic planning principles of environmental scanning, strategy formation, and implementation are not standardized and are used unevenly. Hospital leaders were unable to meet organizational performance expectations and were at risk of further scrutiny and possible reproach by LHIN administrators. The current strategic planning methods used by hospital and board leaders not only were failing to provide the necessary outcomes demanded in the changing health-care environment but also appeared to be totally unrelated to these outcomes.

Ontario was the last province without regional health authorities who determine strategic health-care planning for health-care providers, including hospitals. The new LHIN environment demands improved organizational performance and cost efficiencies

with shrinking health-care dollars. The Ontario health-care environment is at a point where, if clinical and financial performance does not improve, acute-care hospital leaders might have all direction of hospital patient care activities determined by the regional LHINs and MOHLTC. If hospital administrators do not find a way to improve their performance through strategic initiatives using strong strategic planning skills, a risk of losing further autonomy on delivering patient care in their communities exists.

Without a concentrated effort to identify what hospital administrators must do to meet accountability expectations by the MOHLTC and the regional LHINs, hospital leaders will not be successful in developing strategy that will solidify their organization's viability. Strategic leadership is necessary to identify what organizational structural and management and business model changes are necessary to advance patient-care delivery in the LHIN environment. Hospital senior teams, MOHLTC, LHIN, and OHA leaders must work together to find solutions that envelop regional health care and provide cost efficiencies. Hospital administrators must be ready to embrace new concepts of developing health-care strategy for the success of their acute-care institutions.

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APPENDIX A: PROTOTYPE SURVEY INSTRUMENT

How often does your hospital plan?

- 1 – Every year
- 2 – Every two years
- 3 – Every three years
- 4 - Every four years
- 5 - Other

Please use the following scale when responding to items x – x.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital reviews the strategic plan semi-annually.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

Functional area and unit managers participate in developing the hospital strategic plan.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently

5 - Always

Front line physicians participate in developing the hospital strategic plan.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

Front line nurses participate in developing the hospital strategic plan.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

Front line physicians' resource needs are an important consideration when strategically planning.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

Strategic planning at our hospital uses health demographics of the community and service area as part of the planning exercise.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

Our hospital only uses LHIN/MOHLTC expectations as outlined in the *Hospital Accountability Act* to strategic plan.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital has identified clinical key performance indicators (KPIs).

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital has identified financial key performance indicators (KPIs).

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

My hospital has an organizational performance measurement system to capture data for clinical KPIs.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

My hospital has an organizational performance measurement system to capture data for financial KPIs.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

My hospital has an individual with evaluation and measurement expertise.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital has identified an individual whose primary responsibility is to collect KPI data.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital has developed a specific method to share strategic planning information with all hospital employees.

- 1 – Never
- 2- Seldom
- 3 – Occasionally
- 4 – Frequently
- 5 - Always

My hospital has identified an individual whose primary responsibility is to monitor whether objectives identified in the strategic plan are met.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

My hospital has performance measurements for each functional area and unit related to the strategic plan.

1 – Never

2- Seldom

3 – Occasionally

4 – Frequently

5 - Always

APPENDIX B: GLOSSARY OF TERMS

Strategic Planning - Strategic planning formalizes processes; a fixed procedure dissected into specific steps supported by various methodologies. Results are a fully designed plan then incorporated through organizational functional areas within the organization.

Environmental Scanning – An examination of physical and social factors, both inside and outside of the organization, which influences the organization’s ability to meet goals.

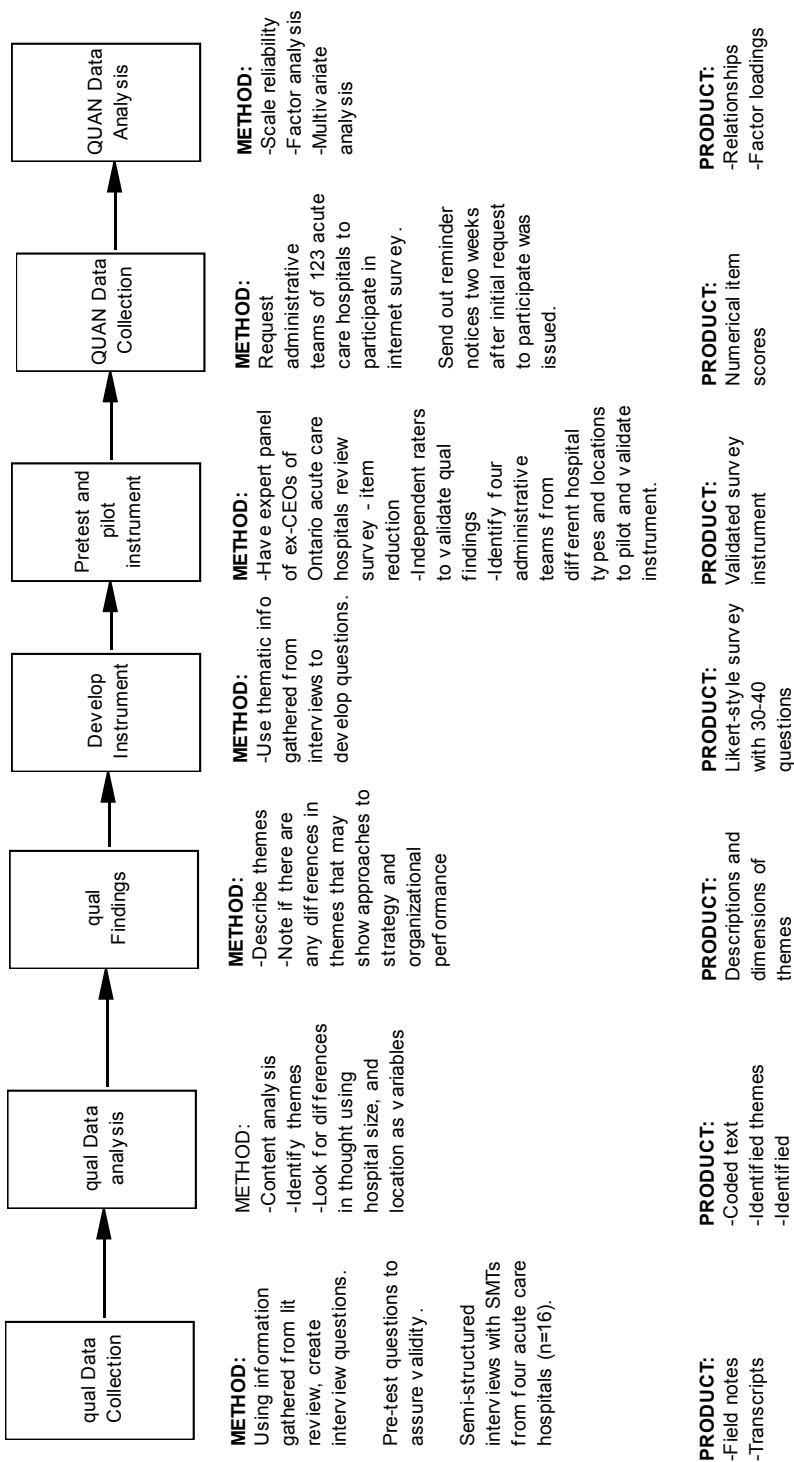
Strategy Formation – Development of a plan based upon changes in the organization’s environment, organizational design, and organizational leadership.

Strategy Implementation – What steps the organization uses to put the strategy into effect and ensure understanding of the strategy throughout the organization.

APPENDIX C: RESEARCH FRAMEWORK

QUANTITATIVE PHASE TWO

QUANTITATIVE PHASE ONE



APPENDIX D: CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

Dr. Michel Bedard is monitoring the research of Teresa Gehman, doctoral student at University of Phoenix. Dr. Bedard agrees not to reproduce, show to, or discuss with anyone any material collected by the student.

This agreement is made and entered into by and between the parties hereto on this 25th day of February, 2008.


Signature

Address: LAKEHEAD UNIVERSITY, 955 OLIVER ROAD, THUNDER BAY ON P7B5E7

Work phone:

807 343 8630

APPENDIX E: PERMISSION TO USE PREMISES

University of Phoenix

**INFORMED CONSENT: PERMISSION TO USE PREMISES, NAME,
AND/OR SUBJECTS**

[REDACTED]

I, hereby authorize Teresa Gehman, student of the University of Phoenix, to use the premises, name, and/or subjects requested to conduct a study entitled Strategic Planning in Ontario Acute Care Hospitals: A Mixed-Method Approach.

Signature:

[REDACTED]

Date

Title CHIEF OPERATING OFFICER

Name of Facility

[REDACTED]
[REDACTED]

University of Phoenix**INFORMED CONSENT: PERMISSION TO USE PREMISES, NAME,
AND/OR SUBJECTS**

I, hereby authorize Teresa Gehman, student of the University of Phoenix, to use the premises, name, and/or subjects requested to conduct a study entitled Strategic Planning in Ontario Acute Care Hospitals: A Mixed-Method Approach.

Signature:



Date

June 25 07

Title

President/CEO

Name of Facility



University of Phoenix**INFORMED CONSENT: PERMISSION TO USE PREMISES, NAME,
AND/OR SUBJECTS**

I, hereby authorize Teresa Gehman, student of the University of Phoenix, to use the premises, name, and or/subjects requested to conduct a study entitled *Strategic Planning in Ontario Acute Care Hospitals: A Mixed-Method Approach*.

Signature



Date 25 06 2007

Title

CEO

Name of Facility



University of Phoenix**INFORMED CONSENT: PERMISSION TO USE PREMISES, NAME,
AND/OR SUBJECTS**

I, hereby authorize Teresa Gehman, student of the University of Phoenix, to use the premises, name, and or/subjects requested to conduct a study entitled *Strategic Planning in Ontario Acute Care Hospitals: A Mixed-Method Approach*.

Signature



Date

Sept 17/2007

Title

Chief Nursing Officer

Name of Facility



APPENDIX F: INFORMATION LETTERS

INTRODUCTION LETTER FOR QUANTITATIVE PHASE 1

Dear

I am a doctoral student at the University of Phoenix conducting a study on the Ontario acute care senior administrators' perceptions of strategic planning. To investigate this topic, I would like to interview the [hospital name] senior management team in a focus group interview session. The benefit gained from your participation is knowledge about how hospital senior administrators approach strategic planning and relationships with internal and external stakeholders within that approach. The final results from this study will be shared with the Ontario Hospital Association for their use in assisting acute care institutions in Ontario improve strategic planning processes.

The interview process is strictly confidential and for research purposes only. I will ask you and your colleagues questions concerning how your organization approaches strategic planning. The transcripts of the focus groups will not identify any participant and the data gathered from the interview is to assist me in developing a survey to be sent to all acute care administrators in the province.

If you would like to further discuss the study or have questions before you participate, please feel to contact me at [REDACTED] or [REDACTED].

Thank you and I look forward to your participation.

Sincerely,

Teresa E. Gehman
Doctor of Management Candidate

INTRODUCTION LETTER FOR QUANTITATIVE PHASE 2

Dear Senior Administrator:

I am a doctoral student at the University of Phoenix conducting a study on Ontario acute care hospital senior administrators' perceptions of strategic planning. The benefit gained from your participation is knowledge about how hospital senior administrators approach strategic planning and relationships with internal and external stakeholders within that approach. The final results from this study will be shared with the Ontario Hospital Association for their use in assisting acute care institutions in Ontario improve strategic planning processes.

Below is a link to a web based survey that will take approximately 15 to 20 minutes to complete. While your participation in this web-based survey is anonymous and confidential, it is important for the study results that your hospital to be identified. Part of the research examines whether the acuity level of care, hospital size, and geographic location has a relationship with strategic planning. The hospital identifier is used to determine whether data results fall into certain ranges, and therefore, generalizations can be made about how hospitals plan strategically based on size, location, or patient acuity level. The data does not reflect positive or negative aspects of strategic planning by any individual hospital.

This process is strictly confidential and for research purposes only. I have provided you with a hospital identifier number. If you agree to participate in the research and have indicated as such by providing your consent, on the subsequent page you will find a field asking for the hospital identifier. Please enter this information in that space.

The link to the survey is:

INSERT LINK

Your hospital identifier number is:

HOSPITAL IDENTIFIER NUMBER

If you would like to discuss further the study before you participate, please feel free to contact me at [REDACTED], or by e-mail at [REDACTED].

Thank you and I look forward to your participation.

Sincerely,

Teresa E. Gehman
Doctor of Management Candidate

APPENDIX G: INFORMED CONSENT

INFORMED CONSENT FORM PHASE 1

STUDY TITLE:

“Strategic Planning in Ontario Acute Care Hospitals – A Mixed-Method Study”

The purpose of this study is to investigate Ontario acute care administrators’ perceptions of strategic planning. Currently no studies exist on the strategic planning process that acute care institutions undertake. Without that information, the MOHLTC and the LHINs can make assumptions strategic planning is performed using certain methodologies, and then expect organizational performance outcomes to be fulfilled. This study is to examine the methods that acute care hospitals currently strategically plan and the relationship to organizational performance.

The following information is to help you decide whether you want to participate in this study. For a study like this, confidentiality of the participants is of vital concern. You are free to decide whether to participate in this study, and can withdraw at any time without affecting your relationship with the researcher or your hospital organization.

All focus group sessions will take place in your hospital in a location of the hospital administrators’ choice. Your responses will be kept completely confidential. The researcher will not discuss or report any specific names, locations, or identifying particulars of the participants with anyone else.

Transcripts of the focus groups will not identify any individual, and no personal or organizationally identifiable information will be shared with anyone. The research results will take every step possible to disguise the identity of the hospital in any published materials or presentations. Tape-recorded focus groups will be transcribed onto a digital file and will have no personally identifying information about the interviewee or participating hospital. The digital files will be kept on an external computer drive in the possession of the researcher. The external drive, interview tapes, and all consent forms will be kept in a safety deposit box for 3 years and then destroyed.

There are no known risks and/or discomforts associated with this study. The benefit to be gained from your participation is knowledge about how senior hospital administrators in Ontario approach strategic planning. Your participation will help to advance our knowledge and understanding of the process. The Ontario Hospital Association will be receiving the results from the study in order to assist their members improve strategic planning on a local level.

By signing this form I acknowledge that I understand the nature of the study, the potential risks to me as a participant, and the means by which my identity will be kept confidential. My signature on this form also indicates that I am 18 years old or older and that I give my permission to voluntarily serve as a participant in the study described. You are signing it with full knowledge of the purpose of the study. You will be provided with a copy of this form for your records.

Signature of Participant

Date

Printed name of Participant

INFORMED CONSENT FORM PHASE 2

STUDY TITLE:

“Strategic Planning in Ontario Acute Care Hospitals – A Mixed-Method Study”

The purpose of this study is to investigate Ontario acute care hospital administrators’ perceptions of strategic planning. Currently no studies exist on the strategic planning process that acute care institutions undertake. Without that information, the MOHLTC and the LHINs can make assumptions strategic planning is performed using certain methodologies, and then expect organizational performance outcomes to be fulfilled. This study is to examine the methods that acute care hospitals currently strategically plan and the relationship to organizational performance.

The following information is to help you decide whether you want to participate in this study. For a study like this, confidentiality of the participants is of vital concern. For the purposes of the research, it is necessary to identify which hospital you represent. You are free to decide whether to participate in this study, and can withdraw at any time without affecting your relationship with the researcher or hospital organization.

By clicking on “I ACCEPT” at the bottom of the screen, you acknowledging that you are at least 18 years of age and your participation in this study is entirely voluntary. Furthermore, you should understand that your participation or nonparticipation would not be reported to any person. The researcher is only aware of which hospital you represent and not the identity of the actual participant. Your survey results will only be available to the researcher on a non-attribution basis. Additional terms and conditions of your participation in this survey are:

1. I may refuse to participate and withdraw my participation at any time without consequences.
2. Survey records and the list of participating hospitals are confidential.
3. At the conclusion of the research, the Ontario Hospital Association will receive the results to improve services they deliver to acute care institutions related to strategic planning.

There are no other agreements written or oral related to the study beyond what is expressed in this consent and confidentiality form.

By clicking “ACCEPT,” I, as a study participant understand the description of the study, and hereby give my consent to participate voluntarily.

- ACCEPT
- DO NOT ACCEPT

APPENDIX H: FOCUS GROUP QUESTIONS

1. What does the term 'strategy' mean to you? What about 'strategic planning'?
2. Could you tell me who is involved in strategic planning within your hospital?
3. Describe the strategic planning process in your hospital? How does it work?
4. How do you determine what should be your goals when planning strategically?
5. How often do you review the approved plan? How do you know if it has been followed? Do you monitor whether performance targets have been met?
6. If you could, what one thing would you change about your strategic planning process?
7. What would you like to tell me about strategic planning that I have not asked?

APPENDIX I: OHA LETTER OF SUPPORT



ONTARIO
HOSPITAL
ASSOCIATION

200 Front Street West, Suite 2800
Toronto, ON M5V 3L1
Tel: 416 205 1300 Fax: 416 205 1301
www.oha.com

May 31, 2007



Dear [REDACTED]

I am writing to you on behalf of the Ontario Hospital Association (OHA) to indicate our support for Teresa Gehman, who is carrying out her Doctoral dissertation on Management and Organizational Leadership entitled, "Strategic Planning and Process in Ontario Acute Care Hospitals: A Mixed-Method Approach".

We are requesting for your consideration in providing interviews to Ms. Gehman with your leadership teams in the early fall of 2007 to discuss how these teams approach strategic planning. The findings of this research will be made available to the OHA and its members upon completion of the study.

The OHA values this work as a way to better understand how acute care hospitals are and can use strategic planning to their benefit. As issues of governance become pressing concerns for hospitals in meeting the needs of the evolving LHIN environment, strategic planning takes on an increasingly vital role.

We thank you in advance for taking the time to support this research. Kindly contact Teresa Gehman at [REDACTED] or [REDACTED] to confirm your participation, or if you have further questions or concerns.

Sincerely,

Lou Reidel
Director, Health Finance and Research

APPENDIX J: FOLLOW UP EMAIL

Date:

Dear Senior Administrator:

A few weeks ago, I forwarded to you a request to participate in a study on Ontario acute care hospital senior administrators' perceptions of strategic planning. The benefit gained from your participation is knowledge about how hospital senior administrators approach strategic planning and relationships with internal and external stakeholders within that approach. The final results from this study will be shared with the Ontario Hospital Association for their use in assisting acute care institutions in Ontario improve strategic planning processes.

If you have not yet had the opportunity to participate in this study, I would ask for a few minutes of your time to complete the survey. This process is strictly confidential and for research purposes only. I have provided you with a hospital identifier number. If you agree to participate in the research and have indicated as such by providing your consent, on the subsequent page you will find a field asking for the hospital identifier. Please enter this information in that space.

The link to the survey is:

INSERT LINK

Your hospital identifier number is:

HOSPITAL IDENTIFIER NUMBER

If you would like to discuss further the study before you participate, please feel free to contact me at [REDACTED], or by e-mail at [REDACTED].

Thank you and I look forward to your participation.

Sincerely,

Teresa Gehman
Doctor of Management Candidate

APPENDIX K: COPYRIGHT PERMISSION

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Response # 162012
 07/18/2007

Teresa E. Gehman
 University of Phoenix

Thank you for your interest in the following Wadsworth material

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 Publisher: Wadsworth
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Sincerely,

Jane Park
Permissions Coordinator

Page 1 of 1 Response # 162012 Requestor email: gehman@tbaytel.net

APPENDIX L: FACTOR ANALYSIS LOADINGS

	Factor 1 LHIN Focused	Factor 2 Regional Focused	Factor 3 Independent	Factor 4 Performance Based	Factor 5 Team Based
Q9	-	-	-	-	0.46
Q10	-	0.38	-	-	0.68
Q11	-	0.59	-	-	-
Q12	-	-	-	-	0.73
Q13	0.44	0.31	-	-	-
Q14	-	-	-	0.36	0.40
Q15	-	0.30	0.64	0.32	-
Q16	0.55	-	-	0.32	-
Q17	0.64	-	-	-	0.37
Q18	0.56	-	-	-	0.53
Q19	0.43	-	-	-	-
Q20	-	0.54	-	0.30	-
Q21	-	0.41	0.35	-	-
Q22	0.46	-	0.39	-	0.34
Q23	-	0.42	-	-	-
Q24	-	-	-	-	0.46
Q25	-	0.60	-	-	-
Q26	-	-	-	0.69	-
Q27	-	-	0.70	-	-
Q28	0.59	-	-	-	-
Q29	0.49	-0.40	-	-	-
Q30	-	-	0.79	-	-
Q31	0.66	-	0.42	-	-
Q32	-	-	-	-	0.30
Q33	-	-	0.56	-	-
Q34	-	-	0.61	-	-
Q35	-	0.61	-	-	-
Q36	-	-	-	0.56	0.50
Q37	0.30	0.42	-	-	-
Q38	-	0.67	-	0.47	-
Q39	-	-	-	0.77	-
Q40	0.49	0.35	-	-	-
Q41	-	0.42	-	0.46	-
Q42	0.71	0.40	-	-	-
Q43	-	-0.56	-	0.44	-
Q44	-	-	0.45	0.47	-
Q45	0.52	-	-	-	-
Q46	-	0.36	-	-	-
Q47	0.54	0.55	-	-	-

Note: Bolded loadings designate highest factor loading and face validity, and are included in that factor designation

APPENDIX M: SURVEY QUESTIONS GROUPED INTO FACTORS

Survey Question	Majority Response
Factor 1 – LHIN Focused	
13. The strategic vision for your hospital is determined by the regional LHIN.	Never
16. When developing your strategic plan, your hospital leaders are concerned with differentiating the patient services that you provide from services provided by other hospitals/providers in the region.	Always
17. Your hospital leaders use the LHIN's strategic goals when considering the strategic directions for your hospital.	Always
18. Front line nurses and/or nurse managers participate in developing the hospital's strategic plan.	Always
19. Your hospital's administrators believe that the LHIN provides you with the resources to assist you in building core competencies to meet your specific organizational strategic goals (examples: funding, expertise, access to data).	Occasionally
28. Internal allocation of financial resources is the primary driver of the strategic plan.	Occasionally
29. Outside funding bodies influence the direction of the strategic goals in your hospital (example, LHIN, MOHLTC).	Frequently
31. If your hospital leadership perceives that the healthcare environment is becoming more turbulent, environmental scanning activities are	Frequently
40. The professional staff utilizes hospital resources according to the strategic goals of the hospital.	Frequently
42. The regional LHIN healthcare vision determines the strategic goals for your hospital.	Frequently
45. In the current strategic plan, the total number of strategic initiatives arising from all strategic plan goals is:	0-10
Factor 2 – Regional Focused	
11. The new strategic plan includes strategic goals from the previous plan.	Occasionally
20. Your hospital leaders use LHIN/MOHLTC performance expectations as outlined in the <i>Hospital Accountability Act</i> to help formulate your strategic plan.	Always
21. When significant changes occur in the healthcare environment, your hospital will change or rewrite the strategic plan.	Frequently

23. Your hospital leaders believe that in order to better utilize scarce resources, patients should only access some general acute care services from other hospitals in the region. Occasionally
25. The strategic plan considers front line physicians' clinical resource needs. Frequently
35. Your hospital's organizational culture promotes the recognition of staff who contributes ideas on how hospital units/services can meet Occasionall
37. In order to deal with unexpected events, your hospital management creates alternative strategic initiatives to ensure that strategic goals are reached. Occasionally
38. Your hospital management's own strategic priorities reflects the LHIN leadership's expectations of performance. Frequently
46. The physicians' determination of clinical needs is the greatest priority when developing your hospital's strategic plan. Always
47. The greatest priority of your hospital when developing your strategic plan is incorporating the LHIN strategic regional health goals into your hospital's strategic goals. Frequently

Factor 3 - Independent

15. Each functional area or patient service unit in the hospital has developed its own tactical plan to meet organizational strategic goals. Always
22. Your hospital leaders are aware of internal competencies and skills, and use them when planning strategic initiatives. Frequently
27. A specific person/team in your hospital is assigned to inform others (staff, physicians, community partners, and public) of the hospital strategic goals and initiatives. Always
30. Your hospital leadership has an organizational performance measurement system to capture data for financial KPIs (example, data system to measure current ratio). Always
33. Your hospital leaders use an organizational performance measurement system to capture data for clinical KPIs (example, capture data on patient adverse events). Always
34. An individual or individuals with evaluation and measurement expertise is on staff at your hospital. Always

Factor 4 – Performance Based

26. Your hospital leadership has identified key clinical performance indicators (KPIs) that tie into the strategic plan and/or LHIN <i>Accountability Agreement</i> (example, myocardial readmission rates,	Always
36. Your hospital leaders refer to an inventory of patient services of other hospitals or health providers in the region before determining your own hospital's strategic goals.	Frequently
39. Your hospital leaders examine how each functional area will create strategic initiatives that support the organizational strategic goals.	Always
41. To meet strategic goals, your hospital leaders set targets and then measure movement towards meeting these targets.	Occasionally
43. Your hospital leadership relies on external sources to provide environmental scanning information (examples, Cancer Care Ontario,	Frequently
44. Your hospital leaders have identified an individuals whose responsibility is to monitor whether objectives identified in the strategic	Always

Factor 5 – Team Based

9. Functional area and patient unit managers are part of the hospital's strategic plan development group.	Always
10. At your hospital, a hospital employee(s) is responsible for creating on a regular basis, reports about population health in your community.	Occasionally
12. Your hospital leaders consult with other regional health providers to decide which facility will provide various patient services.	Frequently
14. Front line physicians and/or physician leaders participate in developing the hospital's strategic plan.	Always
24. Your hospital leaders provide access to education programs or conferences to assist employees in gaining specific skills and competencies that meet organizational strategic goals.	Frequently
32. Your hospital leaders utilize teams or task forces of physicians, nurse managers, and community partners when determining strategic goals.	Always
