

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

ANALYSIS OF THE STRATEGIC PLANNING AND DECISION-MAKING  
PROCESS IN A HOSPITAL SETTING

A graduate project submitted in partial satisfaction of  
the requirements for the degree of Master of Science in

Health Science, Health Administration

by

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## ABSTRACT

### ANALYSIS OF THE STRATEGIC PLANNING AND DECISION-MAKING PROCESS IN A HOSPITAL SETTING

by

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Master of Science Degree in Health Science

Health Administration

The purpose of this project is to demonstrate the application of an integrated strategic planning and decision-making process in a specific health care facility. Various planning and decision-making models are presented and the significant principles are discussed. The models are compared to the actual planning and decision-making process as it occurred at Medical Center of Tarzana in Tarzana, California.

Information regarding the actual process was developed as a result of the author's direct observation and participation. Planning data is developed and categorized into external and internal environment groups and is presented as follows:



A. External Environment

1. Demographic Assessment
2. Competitive Assessment
3. Regulatory Assessment

B. Internal Environment

1. Hospital Activity Assessment
2. Medical Staff Assessment
3. Financial Assessment

The data is analyzed and five planning alternatives are presented. The paper also identifies those issues the hospital governing body considered significant in their selection of specific planning alternatives. These issues include: (1) a positive utilization trend and anticipated service area population growth; (2) the significance of the perinatal and intensive care newborn nursery service; (3) the HSA plan which identified an excess of acute medical-surgical beds, but a shortage of intensive care newborn nursery beds; (4) a supportive medical staff; and (5) pro-forma profitability statements.

Significant findings of the paper are: (1) the formation of the Planning Committee, (2) interpretation of the planning data, (3) development of planning alternatives, (4) the Board of Directors' reactions to these alternatives, (5) the adoption of a 20-Year Master Plan, (6) a description of the strategic planning and decision-making process, and (7) recommendations to the Board regarding the Medical Center of Tarzana's planning and decision-making

process.

Finally, this paper concludes with recommendations by the author regarding the strategic planning and decision-making process as it occurred. These recommendations were discussed with hospital administration, corporate planning staff, and members of the hospital board.

## Chapter 1

### INTRODUCTION

#### INTRODUCTION

This paper focuses on two of the most basic of management functions—those of strategic planning and decision making. The past two decades have witnessed a tremendous interest in the strategic planning and decision-making process by all forms of enterprise: business, government, education, and health care.

While this interest is a rather recent phenomenon in the health care industry, such areas as factory operations and production planning have stressed strategic planning and decision making since the 1930's (Koontz and O'Donnell, 1974). Production managers found early that without effective planning, their mistakes showed up within days as production lines came to a screeching halt through the utilization of incorrect parts or the absence of a needed component. Also, well managed companies have long practiced cash flow planning. But generally in the area of health care, integrated planning and decision making are fairly recent developments as part of the managerial function.

In today's economic climate, the hospital industry is faced with a never ending flow of regulations, varying

public expectations, evolving socioeconomic growth patterns, and ever advancing medical technology. Additionally, facing rapidly escalating health costs, hospitals have begun to realize their fundamental problems are economic rather than scientific or humanitarian.

Thus, the current evolution of the hospital strategic planning and decision making process is no longer occurring at a snail's pace. Hospital management and administration have been thrust into the dynamic 1980's, forcing management to prepare for their future state. The critical step in this evaluation is the adoption of formal planning and decision-making processes which are necessary for the hospital to survive.

#### STATEMENT OF THE PROJECT

This project involves the preparation of data necessary to justify the expansion of an existing Intensive Care Newborn Nursery in an acute care hospital. The document describes the planning and decision-making process hospital administration followed in developing the planning data and support necessary to gain corporate approval and funding of the project.

#### SIGNIFICANCE OF THE PROJECT

The project is significant because strategic planning and decision making are such essential requirements of good hospital management (Koontz and O'Donnell, 1968;

Levey and Loomba, 1973) and are rooted in the basic functions of the hospital governing body and administration.

A second reason that the subject of this project carries significance is that, although many in hospital management recognize the importance of strategic planning and decision making and even understand its basic principles, few have a practical familiarity with the actual process and methodologies of such a formal process. Perhaps this paper will provide some inspiration to those in health care management to undertake the implementation of a formal planning and decision-making process within their organization.

The subject is timely. In the past twenty years, pressures from the external hospital environment have changed dramatically. The 1960's were a transition period for hospitals, causing focuses to change from internal concerns of organization and facility design and construction to an awareness and concern regarding external activities. During this period, significant federal and state legislation pertaining to hospitals was enacted. Government's commitment to the financing of health care with the enactment of Medicare and Medicaid legislation in 1965 has had great significance. In 1966, hospitals were faced with the constraints imposed by Comprehensive Health Planning. This legislation was designed to consolidate categorical health programs and federal financial assistance at the state level. Hospitals have also been under

continued pressure due to recent legislation designed to require planning activities. The California State Certificate of Need Legislation (A.B. 4001, 1976) was implemented in order to allow for a coordinated, cost-effective method of providing health care and planning for all hospitals and health care providers in California.

Facing rapidly escalating health costs, hospitals have begun to realize their fundamental problems are economic rather than scientific or humanitarian. The California Hospital Association describes the current external environment hospitals are faced with quite well when they address Senator Robinson's *Medical and Private Insurance Contracting Reform Acts* (A.B. 799 and 3480, 1982):

Two bills enacted in July will have more impact upon hospitals and physicians than any other legislation since the enactment of the MediCal program in 1965. Our health care financing system has been fundamentally altered. No longer is the primary motivation to provide all the services needed by the patient, within medical judgment, with secondary concern for cost. Budgetary limits, rather than patient care needs, are now the order of the day for hospitals and physicians. The Legislature has decreed that selection contracting will become the basis for reimbursing hospitals for both MediCal and private third-party business.

Today's rapidly changing business environment forces hospitals' management to prepare for their future state.

Thus, the current evolution of the hospital planning and decision-making process is no longer occurring at a snail's pace. Hospital management and administration have been thrust into the dynamic 1980's. The final step in

this evolution is the adoption of planning and decision-making processes which are a necessity if the hospital is to survive.

A review of the current literature suggests that two of the most important functions of management are those of planning and decision making. Many authors suggest that management is essentially the process of making decisions. Levey and Loomba (1973) define a decision as, "the conclusion of a process by which one chooses among available alternatives for the purpose of achieving a set of desired objectives." Koontz and O'Donnell (1974) have described the process leading to the making of a decision as planning. They go on to define planning as "an intellectual and rational process; the conscious determination of courses of action; the basing of decisions on purpose, facts and considered estimates."

A review of planning and decision making in the future will show that hospitals will vary in the level of sophistication of their planning and decision-making process. Some suffering from arrested development will consider facilities planning both the beginning and the end of their needs. Others will lack frameworks for choosing among alternatives generated by their institutional planning systems. The pioneers in the field of planning and decision making will have learned to deal with their current environments by adopting progressive, rational processes enabling them to embrace the issues of significance

affecting the future of health care.

#### DESCRIPTION OF THE STUDY

This is a retrospective and descriptive study of the strategic planning and decision-making process as it occurred in a health care institution. Specifically relevant are those factors the hospital governing body perceived as significant to their strategic planning decision to expand existing services. Much of the actual data presented to the governing body was obtained by the author's actual observations and participation in the process. The governing body's reaction to, and utilization of, this data is described and analyzed in Chapter 4 of this document.

This project was first initiated in May of 1980 when Medical Center of Tarzana hired the author to function as its Director of Planning Activities. This position was created in order to facilitate the strategic planning and decision-making process at the facility. The end result of this process was a presentation to the hospital board of significant and relevant planning data needed for strategic decision making. The board used the data and approved the expansion program.

#### ORGANIZATION OF THE PAPER

The organization of this paper is, somewhat, a reflection of the sequence in which the project was undertaken.



A review of relevant literature on the subject of strategic planning and decision making provided the author with a working knowledge of significant principles which were applied to the hospital setting. An integrated planning and decision-making process is described in Chapter 2.

Chapter 3 describes the methodology used in developing the project and outlines the project goals and objectives. This chapter describes the sources of data, categorizes these data into external and internal variables which impact on the Medical Center of Tarzana, and presents possible limitations. The data is presented as follows:

A. External Environment

1. Demographic Assessment
2. Competitive Assessment
3. Regulatory Assessment

B. Internal Environment

1. Hospital Activity Assessment
2. Medical Staff Assessment
3. Financial Assessment

Chapter 4 presents the results of the project, and relates the project findings to each objective. Significant findings in this chapter are: (1) the formation of the Planning Committee, (2) interpretation of the planning data, (3) development of planning alternatives, (4) the Board of Directors' reactions to these alternatives, (5) the adoption of a Twenty-Year Master Plan, (6) a description of the strategic planning and decision-making

process, and (7) recommendations to the Board regarding the Medical Center of Tarzana's planning and decision-making process.

The project is concluded in Chapter 5. Recommendations are presented regarding the strategic planning and decision making which might be applied in other hospital settings. Finally, areas for future study are suggested.

## Chapter 2

### BACKGROUND

#### REVIEW OF PERTINENT LITERATURE

This section discusses the available literature on the subject of planning and decision making. A literature search was conducted by reviewing the *Cumulative Index of Hospital Literature* published by the American Hospital Association, searching references cited in journals and books on the subject, and through consultation with various hospital executives and planning consultants.

A reasonable body of literature exists both in book and journal form relating generally to the separate subjects of hospital planning, decision making and trustees. A substantial amount of information is also available which is descriptive of planning processes and decision models. There is, however, a limited amount of material which brings together the topics of planning and decision making into one integrated process.

#### HISTORICAL PERSPECTIVE

As one searches the literature it becomes clear that the history of strategic planning, from a general management perspective, is only about twenty years old (Jaeger,

1982). Writing on the theory of decision making is not much older (Edwards, 1954).

The history of strategic planning or decision making in hospitals is brief. Not until the mid-1970's did articles begin to appear in hospital literature (Zimmerman, 1975; Allen, 1976; Harmon, 1976; Nelson, 1976; Tyne, 1976). This lag in attention, however, should not be surprising. Hospital management, like that of any other industry, only responds as necessary to meet the challenges of internal and external pressures.

In the past twenty years, pressures from the external hospital environment have changed dramatically. The 1960's were a transition period for hospitals causing focuses to change from internal concerns of organization and facility design and construction, to an awareness and concern regarding external activities. During this period, significant federal and state legislation pertaining to hospitals was enacted. Government's commitment to the financing of health care with the enactment of Medicare and Medicaid legislation in 1965 has had great significance. In 1966, hospitals were faced with the constraints imposed by Comprehensive Health Planning. This legislation was designed to consolidate categorical health programs and federal financial assistance at the state level. Hospitals have also been under continued pressure due to recent legislation designed to require planning activities. The California State Certificate of Need Legislation (A.B. 4001,

1976) was implemented in order to allow for a coordinated, cost-effective method of providing health care and planning for all hospitals and health care providers in California.

The development of planning and decision-making processes in hospitals has been strongly encouraged by the American Hospital Association. This has been evidenced by the 1973 publication, *The Practice of Planning in Health Care Institutes*. This report outlined a broad set of guidelines and methods for establishing planning and decision making process.

Planning has long been recognized as an important element of the overall management function, yet the development of a formal process in hospitals is rather recent. Earliest hospital planning efforts, such as facility planning, were heavily directed towards the design and construction of physical facilities. This focus on facilities occurred during periods of rapid hospital growth characterized by bed capacity shortages and government funding incentives through the passage of legislation such as the Hill-Burton Program in 1946. Architects and engineers were usually the key planners and decision makers in this process.

The external counterpart of hospital facility planning was, in many areas of the country, voluntary areawide planning. This planning, in most cases, was initiated by the providers themselves in conjunction with other community leaders. There was, however, minimal integration between

the internal and external hospital planning process and areawide planning concerns (Melum, 1981).

The interaction between internal and external planning evolved gradually during the 1960's. As this evolution occurred, hospital planning eventually took on the broader focus of institutional planning with an emphasis on special programs and services. As part of this development process, annual or long-term objectives for major existing programs were established. To varying degrees, hospitals began to utilize these objectives to measure their performance (Melum, 1981). Future decisions were then based on perceptions of past performance.

#### PLANNING DEFINED

Russell Ackoff (1970), an early writer in the field of management, provides a rather complex definition of planning in general by saying:

Planning is a process that involves making and evaluating each set of interrelated decisions before action is required in a situation in which it is believed that unless action is taken, a desired future state is not likely to occur, and that, if appropriate action is taken, the likelihood of a favorable outcome can be increased.

At another point he states, "Planning is the design of a desired future and of effective ways to bringing it about" (Ackoff, 1970). Others have used the phrase, "planning is anticipatory decision making" (Jaeger, 1982).

One can better understand the basic idea of planning by examining the elements that the definition incorporates.

These elements are:

1. Systematic - planning involves the interaction of multiple interdependent decisions. The decisions themselves may be simple or complex, but they form a system. The attempt to determine and evaluate these interactions and the possible outcomes requires both techniques and a framework that are systematic.
2. Process - planning is not a single act or action; it is an ongoing series of interrelated actions. The entire value of planning comes from the formal acknowledgement that conditions affecting the organization will change over time and that some of these changes are controllable by management. The substance of planning is the process of identifying which changes can be controlled and determining what behavior is preferable.
3. Future - the decisions developed must deliberately affect the future behavior of the organization. Decisions that affect only current behavior are operating, not planning, oriented. However, planning is not the development of future decisions. It is development of present decisions that affect (or anticipate) the future.
4. Choice - a choice between decisions that will produce alternative behaviors must be present. Where no choice is possible, no decision is necessary. Furthermore, there must be a belief that through the planning, desired behaviors can be achieved instead of undesirable behaviors.
5. Decisions - the unit of activity involved is the decision. The activity must be performed by those recognized as responsible for the conduct of the organization, that is, management (the board, CEO, managers, etc.) (Jaeger, 1982).

Planning involves a decision of some kind affecting the future of the organization. Some assumptions are involved because the future is seen only dimly. Possible courses of action must be developed and a choice made among them. Some process must be used to arrive at that decision. Finally, planning involves a system of bringing

together needed information and presenting it so as to identify the possible choices and lead to a decision to modify some future behavior of the organization in a favorable manner.

#### PHILOSOPHIES OF PLANNING

Three philosophies have been identified as underlying planning (Ackoff, 1970; Levey and Loomba, 1973; Bodzek, 1979). One philosophy, dating back to the late 1950's, was given the name "satisficing," which is doing just enough to get by (Simon, 1955). Others have called this philosophy "muddling through" (Lindblom, 1959). It is not doing the best job possible, but being certain to do at least enough to make some decision regarding the future.

Another philosophy that is often applied is called "optimizing." The best possible outcome is identified and everything that will lead the organization to it is utilized (Jaeger, 1982). Simon (1957) described the same philosophy and termed it "maximizing." Most organizations try to optimize on at least some occasions. As a philosophical approach, it helps to pull things together and suggest solutions in dealing with certain kinds of problems.

The third planning philosophy discussed in the literature is "adaptivizing" (Ackoff, 1970). This philosophy has been called the "entrepreneurial man" approach by others (Jaeger, 1982). The "adaptivizer" will deliberately



change the organization to change its own behavior. Instead of telling people that they cannot do this in the future or that they must do that, such a person will create organizational incentives that make others want to stop doing what they are doing or to do the new things. Obviously, it is much easier to describe the application of this idea than it is to accomplish. However, this philosophical approach to planning is very effective for certain kinds of situations.

In reality, most organizations <sup>combine</sup> merge all three philosophies when planning. The original plan is usually <sup>most favorable</sup> optimal for some future <sup>action for planning is a series of stages</sup> scenario envisioned for the organization.

Adaptivizing strategies are developed to minimize the disruptive nature of the changes that must be made. Finally, the real events and pressures force many groups to muddle through. What is important is to understand the compromises made in the planning process. This ensures the best position, given the constraints, to approximate the desired outcome.

Planning is an imperfect process. Plans must be flexible. The implementation of plans is often a highly political undertaking. Still, every reasonable effort must be made to control the fate of an organization. The philosophies of planning can provide helpful insight about corporate actions in an attempt to achieve that control.

## MODES OF PLANNING

Planning, as an integral component of management, is a global term. As a practical matter, authors usually add distinctive terms to indicate specific planning situations and reserve the use of corporate planning for either the sum of an organization's planning efforts or, more loosely, its long-range or strategic efforts. The lack of a standardized terminology produces some inconsistencies in the literature. Table 1 displays a clear and concise summary of different planning modes.

Strategic planning, by definition, is long range, five to ten years in the future. The more irreversible decisions are, the closer they come to being mission or strategic in nature. For example, should a particular institution be an acute-care hospital, or should it move into long-term care?

Operational planning is usually concerned with decisions affecting the overall operations of an organization. It involves operating budgets and similar types of plans that generally occur on an annual or semi-annual basis.

Tactical planning refers to decisions made on a daily or weekly basis. An operating room schedule or an individual's work schedule are examples of tactical planning. Tactical plans, by nature, are very short range and easily changed.

Hospitals entered the project or program planning process in a formal way due to the impact of the

### MODES OF PLANNING

Type	Scope	Time	Application	Example
Strategic	Comprehensive	Long-range	Expansion Acquisition Merger Divestment	Mission change
Operational	Function	Mid-range	Financial Manpower Marketing Process	Budgets Organizational charts
Tactical	Unit	Short-range	Routines	Schedules
Project/ Program	Varies	Varies	Facilities Services	Construction
Contingency	Varies	Short-range	Disasters	Weather Mass casualties

TABLE 1

Hill-Burton Act. P.L. 93-641 also stresses program planning and a majority of the planning literature addresses this element of the planning and decision-making process. Program planning tends to focus on a single event. Although very complex and long term, the planning of a new or replacement hospital is a good example of project planning.

Finally, there is contingency planning. This type of planning is usually short term in nature. It is reactive rather than pro-active and usually it is not always utilized in response to unforeseen difficulties which arise in the course of other planning modes. All of these elements are part of the corporate planning and decision-making process. All elements influence one another and all need to be coordinated in order to obtain the maximum benefit from each.

#### MULTI-INSTITUTIONAL SYSTEMS PLANNING

Modes of planning will vary among institutions. Multi-hospital systems face planning challenges similar to those of single hospitals, yet system hospitals deal with these challenges in an environment made considerably more complex by greater diversity and multiplicity of participants, service role options, government regulations and resource allocation decisions (Rice, 1980). These challenges are displayed in Table 2.

The major difference between solo and system hospitals

**Table 2**  
**Planning Challenges Comparison**  
**Solo versus System Hospitals**

<i>Generic challenges</i>	<i>Solo hospital issues</i>	<i>Hospital system issues</i>
Pressures to plan	<ul style="list-style-type: none"> <li>• P.L. 93-641</li> <li>• JCAH</li> <li>• Local HSA</li> <li>• Rate review</li> </ul>	<ul style="list-style-type: none"> <li>• Competition</li> <li>• Changing needs</li> <li>• Cost containment</li> <li>• All solo issues</li> <li>• Multiple HSAs</li> <li>• Greater diversification challenges</li> <li>• Greater complexity of operations</li> </ul>
Participants	<ul style="list-style-type: none"> <li>• Board</li> <li>• Medical staff</li> <li>• Community leaders</li> <li>• Department heads</li> <li>• Consultants</li> </ul>	<ul style="list-style-type: none"> <li>• Local participants as for solo hospital</li> <li>• Corporate board</li> <li>• Corporate staff specialists</li> <li>• Specialist consultants</li> </ul>
Timing	<ul style="list-style-type: none"> <li>• Annual cycle to precede budgeting</li> <li>• 3-5 year horizon</li> <li>• 3-6 month process</li> </ul>	<ul style="list-style-type: none"> <li>• Annual cycle to precede budgeting</li> <li>• 3-10 year horizon</li> <li>• 6-9 month process</li> </ul>
Integrate unit plans	Balance departmental plans and budgets	Balance hospital/subsidiary/headquarters plans and budgets
Internal politics and personalities	Ego and professional needs of: <ul style="list-style-type: none"> <li>• Medical staff</li> <li>• Department heads</li> <li>• Board members</li> </ul>	Ego and professional needs of: <ul style="list-style-type: none"> <li>• Unit CEOs</li> <li>• Local unit board members</li> <li>• Corporate board members</li> <li>• Corporate department heads</li> </ul>
External politics	<ul style="list-style-type: none"> <li>• Community leaders</li> <li>• HSA/state regulations</li> <li>• Some federal concerns</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple communities, HSAs, state regulations</li> <li>• More extensive concern over FTC, Justice Dept., IRS, and HHS at federal level</li> </ul>
Horizontal diversification	<ul style="list-style-type: none"> <li>• Satellite facilities</li> <li>• Outreach services</li> <li>• Shared services in locale</li> </ul>	<ul style="list-style-type: none"> <li>• All solo issues</li> <li>• Adding units via affiliation, contract, or merger in diverse geographic areas</li> </ul>
Vertical integration	Health care campus at hospital site: ambulatory to long-term care	Ambulatory care to tertiary care, housing, and long-term care at multiple sites
Link to financial planning	Emphasis on capital budget and departmental operating budgets	<ul style="list-style-type: none"> <li>• Similar concern over operating budget, with more aggressive capital budgeting, cash flow analyses, and investment because of large dollar volume</li> <li>• Greater long-range forecasting</li> </ul>
Data systems	Integration of clinical with management applications	<ul style="list-style-type: none"> <li>• All solo issues</li> <li>• Multiple on-line access points</li> <li>• Greater use of computer modeling systems</li> </ul>

Source: Rice, 1980.

with respect to planning and decision making can be attributed to the corporate perspective of a hospital that is part of a multi-hospital system. The system hospital, unlike the solo institution, must be sensitive to the goals of the system as a whole. Thus, planning occurs on two distinct levels—the local level and the corporate level. The necessary planning interface distinguishes between solo and system hospitals. Four distinct relationships can arise between the corporate and the institutional levels of planning (Connors and Spaulding, 1982):

1. Coordinating - the authority and responsibility to take every reasonable means of action to achieve agreed-upon planning objectives.
2. Consulting - the authority and responsibility to participate in and initiate special studies.
3. Executive - the line of authority and responsibility to direct the activities of others and to act on a plan.
4. Monitoring - the authority and responsibility to examine and measure plans according to criteria, budget, or standards.

Rice (1980) has categorized multi-institutional hospital planning into three generic planning models: the federation model, cooperative model, and the corporate model (see Table 3).

The characteristics of the planning process within each of these models are determined by the basic operating philosophy of the system. Where the system exists only as a means to achieve the hospital's ends, i.e., federation model, the planning process is built up from each hospital's assessment of its unique resource needs. The

## Hospital Systems Planning Models

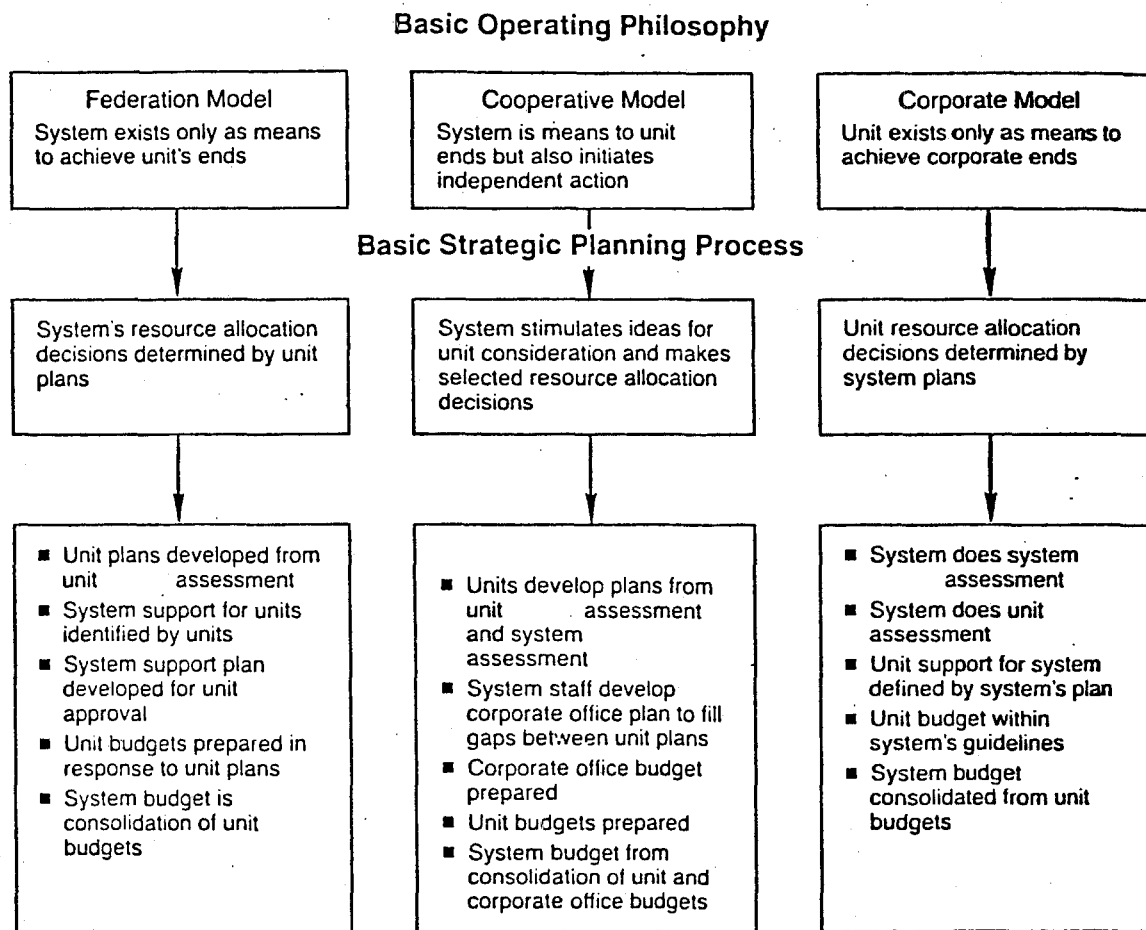


Table 3

system's operating plans and budgets are therefore only a consolidation of the hospitals' plans and budgets.

Within the corporate model, considerably more centralization and "top-down" decision making is evident. Where the individual hospital exists only as a means to achieve the corporation's ends, the planning process is initiated and managed by corporate headquarters staff. Central office staff perform the hospitals' assessments of needs and local operating budgets are developed within closely defined corporate parameters.

The cooperative model represents a middle ground between the extremes of the other two operating models. The cooperative planning process is initiated simultaneously at the local hospital and at corporate levels. Each hospital's strategic plan is based upon an assessment of its strengths and weaknesses by both local and corporate policymakers. Opportunities for corporate support and for filling service role gaps between hospitals' plans are mutually identified by hospital and corporate leadership. The overall cooperative strategic plan and budget therefore not only are a consolidation of the hospitals' plans and budgets but also include certain independent initiatives as well.

It seems apparent, then, that there are both advantages and disadvantages to planning within this system (Connors and Spaulding, 1982). The advantages include the following:



1. A stronger commitment to long-range planning;
2. Internal comparison and collaboration allow member institutions to share information;
3. An increased frequency of project planning;
4. Increased power as a result of the collective resources of the system;
5. Higher and broader level of expertise not available to a single institution;
6. Extensive environmental assessment;
7. An ability to be innovative;
8. An ability to attract skilled personnel.

Though the advantages are great, there are nevertheless disadvantages to planning within a multi-hospital system. Some of these disadvantages are:

1. Unwarranted, excessive centralization;
2. A lack of sensitivity to local needs;
3. An increased bureaucracy.

#### DEVELOPMENT OF A PLANNING COMMITTEE

The often rigorous planning process and the resulting strategic decisions require a broad range of expertise and input not usually within the purview of any individual manager charged with the task to make a change or improve hospital services or policies. Participant planning is the key to constructive future growth (Ross, 1980; Haddad, 1981; Becker, 1982).

A representative planning committee that is responsible to the Board of Directors should include members of the board, medical staff, and hospital administration. In

addition, individuals with strong fiscal and planning skills should be involved, as should first-line managers (Ross, 1980). Members of the planning committee should be selected for their leadership capabilities within the institutions, knowledge of the institution as a whole, and ability to communicate and share ideas with others (Haddad, 1981). In any case, the quality of decision making, resulting from the planning process, is enhanced as a result of the breadth and depth of expertise of the planning committee members.

#### DECISION MAKING DEFINED

A decision is the conclusion of a process by which one chooses among available alternatives for the purpose of achieving a set of desired objectives. Decision making involves all the thinking and activities that are required to produce a choice among alternative courses of action. The making of decisions is the essence of management. Planning, organizing, controlling, leading, and all other aspects of management are executed through the making and implementing of decisions (Levey and Loomba, 1973). Koontz and O'Donnell (1974) describe decision making as the selection from among the many alternatives of a course of action. They go on to state that decision making is the core of planning.

Managers sometimes see decision making as their central responsibility because they must constantly choose

among alternatives regarding what is to be done, who is to do it, when it is to be done, and most importantly, how it is to be done. Decision making is often considered the final step in the planning process (Koontz and O'Donnell, 1974; Jaeger, 1982).

This definition of decision making has been condensed to its basic elements by Levey and Loomba (1973). These elements are:

1. Decision maker and a set of objectives;
2. Context and environment of the decision problem;
3. Assumptions regarding the future;
4. Alternative courses of action;
5. Consequences of alternative courses of action;
6. Choice according to decision criterion;
7. Implementation and control.

These elements are present in every decision problem.

#### PHILOSOPHIES OF DECISION MAKING

The essence of decision making is the evaluation and choice between multiple alternatives developed during planning. The reality of multiple alternatives forces the decision maker to examine some basic issues. First, which set of alternatives should be formally included in the decision-making process; secondly, what is the relative degree of importance of the chosen set of alternatives; and lastly, how should each be evaluated (Levey and Loomba, 1973).

The decision maker will either satisfy or optimize objectives when choosing among alternatives (Simon, 1957; Bodzek, 1979) (see previous discussion on Philosophies of Planning for comparison of satisficing, optimizing, and adaptivizing in planning).

The satisficing philosophy implies an insignificant departure from established policies and practices. Other aspects of this approach involve only moderate increases in resource requirements, no significant change in the organizational structure, and little or no provision for error or change (Levey and Loomba, 1973). Not surprisingly, satisfying decisions seldom produce significant breaks with the past.

The optimizing approach, on the other hand, generally occurs as a result of analyzing multiple alternatives against the status quo and evaluating which have the potential for the greatest results. Characteristic of the optimizing approach is a departure from policy and usual practice if necessary, the expenditure of resources to attain desired end results, and the establishment of measurable objectives.

In any case, decisions are molded by the individuals who constitute an institution's governing board and top management, i.e., the decision makers. They not only reflect the personal values, preferences, experiences, and beliefs of these individuals, but also often are the direct products of the individuals' hierarchical positions

and influence within the organization (Peters, 1982).

#### MODES OF DECISION MAKING

Decisions and the decision-making process can be classified and studied from a number of different perspectives. For example, depending upon the level of organizational hierarchy, decisions can be classified into strategic, administrative, or operational (Ansoff, 1965).

Strategic decisions refer to defining the organization's relationships with the outside environment. In the health care setting, decisions regarding hospital location, size, programs, and major capital investments are examples of strategic decisions.

Administrative decisions deal with the organizational structure of authority, responsibility, and accountability. Development of internal services and resource acquisition such as facility design, work patterns, and employment are examples of administrative decisions.

Finally, operation decisions are made to deal with routine and day-to-day situations. Scheduling or control of inventories are examples of operational decisions (Levey and Loomba, 1973).

#### INTEGRATING THE PLANNING AND DECISION-MAKING PROCESSES

In researching the literature, various elements appear to be universal in describing different models of the planning and decision-making processes. These similarities

become clear when the elements are displayed as in Table 4, which summarizes three models of the planning and decision-making processes as they have been described by different authors. It becomes apparent that the elements or steps of the planning or decision-making process are nearly identical. Ackoff (1970) supports the similarity of planning and decision making, but identifies one important difference. In certain cases, a decision can be made without planning, but every aspect of formal planning, by definition, requires decision making. Planning is, in effect, anticipatory decision making.

#### HOSPITAL GOVERNING BODY

In addition to their long-held legal and fiduciary responsibilities, governing boards are increasingly being viewed as being accountable for meeting the needs of the public or community that the hospital serves (Hinds, 1981). Today's environment encourages the structure of governance and management of institutions to organize along corporate lines. Hospital governing boards are no longer spectators in the management arena, but are active participants, reviewing management decisions for their compliance with board-developed policies (Tuller and Kozak, 1979).

The role and responsibility of the hospital administrator also continues to develop along patterns generally found in business organizations. That is, the administrator, or chief executive officer, has in many cases,

Planning and Decision Making  
Process - Summary

Six Steps of Planning	Four Conditions of Rational Decision Making	Seven Elements of Consideration In Decision Making
1. Awareness of An Opportunity (Problem)		
2. Establishment of Objectives	1. Attempt to Reach Some Goal That Cannot Be Obtained Without Positive Action	1. Decision-Maker and A Set of Objectives
3. Premising - Using Data to Develop Planning Assumptions	2. Must Have a Clear Understanding of Courses By Which a Goal Could be Reached Under Existing and Future Circumstances and Limitations	2. Context and Environment of the Decision Problem 3. Assumptions Regarding The Future
4. Develop and Examine Alternative Courses of Action		4. Alternative Courses of Action
5. Evaluate Alternatives with Respect to Premises and Goals	3. Analyze and Evaluate Alternatives in Light of Sought Goal	5. Consequences of Alternative Courses of Action
6. Select a Course of Action - The Point at Which the Plan Is Adopted	4. Select the Alternative Which Best Satisfies Goal Achievement	6. Choice According to Decision Criteria
		7. Implementation and Control

TABLE 4

become responsible for the development and evaluation of program policy and program alternatives for board consideration and is identified as the single point of accountability for the execution of board policy. Within multi-hospital systems, the role of the administrator of each institution resembles that of a chief operating officer, who is responsible for achieving specified operational objectives (Tuller and Kozak, 1979; Rice, 1980).

The hospital governing board exerts its greatest impact on the facility for which it is responsible when it becomes involved in the formal strategic planning and decision-making process. Functioning in such a mode, the board most likely must evaluate pertinent data and analyze alternatives, which may have been developed by the planning committee.

As the board acts, it may follow procedures which may include many of the steps involved in the planning and decision-making process. According to Longest (1980), at the governing board level, these include:

1. Environmental assessment - if a hospital is to be well managed, its board and administrator must first view it as an open system existing in an environment. The manner in which they assess and respond to the hospital's external environment will have more effect on the successful management of the institution than any other factor. Environmental assessment means two things:  
(1) predicting changes in the environment, and  
(2) predicting the impact of those changes on the operation of the hospital so that the board and administrator can take appropriate actions.
2. Strategy formulation - the second thing that must be done is the formulation of good strategy, i.e.,



the string of decisions that determines the character of the hospital and gives it direction in the marketplace. The formulation of good strategy requires that the board and administrator take their foreknowledge of the environment in which they will operate (with the threats and opportunities in clear view) and shift to active, positive thinking about their response to the environment. They must ask: "What will be the objectives of our hospital and what steps must we take to achieve them?" At the hospital level this strategic response must:

- a. Identify the particular services that the hospital *should* and *will* provide.
- b. Select the basic ways in which these services will be created and provided.
- c. Determine the major steps necessary to move the hospital from its present course to the desired one.
- d. Establish the criteria and the standards that will be used to measure performance.

Strategy formulation (when all four of the above dimensions are present) will permit the development of meaningful statements of objectives for the hospital, which in turn will provide guides for the development of increasingly specific objectives down through the divisions and departments to the level of the individual worker.

3. Policy development - this step requires the balanced participation of not only the board and administrator, but increasingly, the medical staff, because policies will serve as the basic guides to the successful implementation of strategy from the level of the hospital's overall objectives down to specific objectives of each department. Policy decisions must be developed and used in such areas as service mix, patient mix, pricing, personnel, and finance, to name a few important examples.
4. Organization design - the next step in the effective management of the hospital is the process by which formal systems of specialization, coordination, status, authority, communications, responsibility, and accountability are designed. The strategic response to the hospital's environment is carried out by an organization, and unless the

organization is well designed for the job, the best strategy will yield only mediocre results. If the environment, strategy or resources of the hospital never changed, the organization design problem would be rather simple: management could find the best design and keep it. In the "real world" of the hospital, all of these things change continually. Thus, according to contingency planning, the hospital organization structure (at least its component parts) must change periodically. Management must be open to the idea that the design of the organization is a function of many contingencies (most notably environment, strategy, and resources), and they must function as change agents when the design does not best fit these contingencies.

5. Implementation - once management has cleared the hurdles of environmental assessment, strategy formulation, policy development, and organization design, there remains the challenge of "making things happen" in the hospital. Management does not give patient care, nor do they keep books, sweep floors, or paint hallways. But they are responsible for seeing that all of these things and many others get done.

The variable factors (that is, environment, strategy, and resources) dictate that management's response to implementation must "fit" the particular mix and intensity of those variables in a given situation. The environment (through regulatory requirements, traditional and emerging expectations, and the market force of unmet demand) dictates that the strategy of the typical hospital should be to provide patient care, participate in educational processes, and conduct research of various types, and do these things in a high quality way. The variable of resources (especially their increasing costliness) dictates that this strategy must be accomplished in the most productive possible way.

6. Evaluation - the board and administrator are also responsible for evaluating everything that goes on in the hospital from the initial strategic response to the environment through the implementation component. Given the multiple objectives of the hospital (objectives that are very difficult to be specific about) and the difficulty of evaluating success or failure in achieving those objectives, management must turn its attention to an evaluation of the programs or

components of the organization.

7. Change - the main area of responsibility for the board and the administrator is to provide for change when effective evaluation indicates that what is desired is not being achieved. It is important to note that this feedback goes to every component of management's responsibility.

#### PROJECT SETTING

The setting for this project, Medical Center of Tarzana, is a 200-bed general acute care proprietary hospital located in Tarzana, California.

This hospital serves as a major tertiary care center to the residents, providers, and primary health care institutions of the Northwestern area of Los Angeles County, consisting of H.F.P.A.'s 903 (San Fernando), 905 (Van Nuys) and 907 (Burbank).

Medical Center of Tarzana opened in October, 1973. Since January of 1975, the facility has maintained an average yearly occupancy in excess of 80 percent. With 27 licensed obstetrical beds, the annual delivery rate has exceeded 2,000 deliveries for the last three years and the trend appears to be rising.

Medical Center of Tarzana also operates a licensed three-bed Intensive Care Newborn Nursery (I.C.N.N.) unit. The I.C.N.N. is recognized by California Children Services (C.C.S.) and participates in Los Angeles County's Infant transport team consisting of a Neonatologist and support staff to transport critical infants born at

primary perinatal facilities to the I.C.N.N. unit when necessary. The existing three-bed unit is full much of the time, necessitating frequent denial of transport and admission of these critical infants in the local service area. The average occupancy of the unit of the last eighteen months has exceeded 100 percent.

The State of California recognizes a need for additional I.C.N.N. beds as defined in the Los Angeles County *Health Systems Plan*. The most appropriate way of bringing the needed capacity of this regionalized service into use is through expansion of existing licensed services. Such an approach makes efficient use of trained staff, better utilizes specialized physicians and avoids unnecessary duplication.

In August, 1980, the Medical Center of Tarzana submitted to the State and was granted a Certificate of Need for the expansion of the existing licensed three-bed I.C.N.N. The project added twelve additional I.C.N.N. beds to the unit. Other spaces for expansion of the hospital's laboratory, relocation and consolidation of respiratory therapy, offices for social service, expansion and consolidation of business office, and an expansion of the community education/conference room were also included in the \$4,000,000 construction and remodeling project.

New construction of approximately 12,500 square feet now underway involves twin two-story additions adjacent to the north and south exterior walls of the hospital's

existing outpatient surgical center. It is planned that the new I.C.N.N. at Medical Center of Tarzana will be completed and ready for operation early in 1984.

The above-described program is one of five alternatives developed under the direction of the author, the hospital planning committee, and corporate and outside planning consultants. Reporting directly to the administrator, it was agreed that over a period of a year, the author would compile as much of the generally accepted planning data as possible, would analyze and present this data to the hospital administrator and the Board, would act as administrator's representative on the Hospital Planning Committee, and coordinate the activities of the corporate and outside consultants.

## Chapter 3

### PROJECT METHODOLOGY

#### STATEMENT OF PROJECT

This project is a documentation of the planning and decision-making efforts conducted at Medical Center of Tarzana during their 1980 expansion program. This project is intended to serve as a tool of enlightenment in the continual educational effort to make theory understandable in the context of its real-life applications. It is, in this sense, a "case study" through which certain planning and decision-making principles may become more valuable and useful through the utilization of specific examples.

#### PROJECT GOAL

The goal of this project is to gain an understanding of the planning and decision-making process in a hospital setting, and make recommendations to the governing body of Medical Center of Tarzana regarding that process as it occurred at that facility during their 1980 expansion efforts.

#### PROJECT OBJECTIVES

Supporting this goal, and in order to complete this project, the following objectives will be developed:

Objective 1. The first objective is "to describe in detail the actual planning and decision-making process followed by the Medical Center of Tarzana in the expansion of their Intensive Care Newborn Nursery (I.C.N.N.)."

Objective 2. The second objective is "to compare the actual planning and decision-making process at the Medical Center of Tarzana with its formal public process and to existing planning and decision-making models."

Objective 3. The third objective is "to analyze the planning and decision-making process with respect to its impact on the overall development of the hospital."

Objective 4. The fourth objective is "to make recommendations regarding the planning and decision-making process at Medical Center of Tarzana which will enable their future efforts to be carried out in a more effective manner."

#### DEFINITIONS

Having introduced the project, and the use of many professional terms, it is necessary to define certain specialized terminology utilized in the discussion of this project.

Active Medical Staff. Physicians who have applied for privileges, have been accepted by the Executive Committee and Board of Directors, and utilize the hospital on a regular basis.

Ancillary Services. The service departments in the hospital that provide for inpatient and/or outpatient therapeutic and/or diagnostic procedures. Examples include departments such as Pharmacy, Laboratory, and Radiology.

Available Beds. Those beds which are staffed and not under construction or in suspension.

Governing Board. Comprised of twelve members, representing the corporation, the hospital, and the community; retains the ultimate responsibility for the overall operation of the hospital. Hospital administration and the hospital Chief of Staff act as ex-officio members of the Governing Board. Also referred to as the Board of Directors.

Governing Body. A general term incorporating the hospital Governing Board, hospital administration, and the hospital Chief of Staff. All members of the body have equal status and input.

Intensive Care Newborn Nursery (ICNN). A specialized unit in an acute care hospital designed to treat newborns weighing less than 1200 grams. Due to their extreme specialization, these units are extremely costly to equip, staff, and operate. Because of these limitations, these units are only located in specifically designated hospitals in each service area.

Master Plan. A formulation of long-range goals, and a plan for reaching these goals.



Patient Days. Average daily census multiplied by the number of days in the period being studied.

Percent of Occupancy. Actual patient days divided by available beds, multiplied by the number of days in the period being studied.

Service Area. The geographic region surrounding the hospital in which the population served by the hospital resides.

Solo Hospital. A hospital which is not part of a group, such as an investor-owned corporation, non-profit chain, association, or consortium.

System Hospital. A hospital which is part of a group such as an investor-owned corporation, non-profit chain, association, or consortium.

Utilization. The physician's usage of inpatient and outpatient services.

#### SOURCES OF DATA AND THEIR MEASUREMENT

The data available for effective strategic planning and decision making at Medical Center of Tarzana is available in several degrees of detail from many sources. The hospital planning committee will begin its efforts with a thorough assessment of the hospital's external and internal environments. An accurate assessment of these factors by planners and decision makers generates the data which sets the boundaries of future hospital operations, defines the actual and potential markets, and provides the

basis for assessing the Medical Center of Tarzana's position in relation to other area hospitals.

#### EXTERNAL ASSESSMENT

The full range of external variables affecting Medical Center of Tarzana need to be realistically identified so that the potential impact of these variables on the hospital can be assessed. The external assessment and analysis will involve many factors including demographics of the area, other hospital competition, and regulation.

##### Demographic Assessment

A key external variable are those characteristics of those population groups served by the hospital. These groups constitute the hospital's service area. Developing an understanding of the probable characteristics of the service area provides important clues as to the types of services and the quantity of services that are, and will be required in the future.

##### Competitive Assessment

Assessing the institution's key competitors, their strengths, weaknesses, and future plans is an important part of the strategic planning and decision process. This assessment will involve developing data regarding key competitors' market positions, utilization characteristics, major changes in services and programs, and financial positions and resources. Area competition data will be

compiled from any number of sources among which are hospital disclosure reports to the California Health Facilities Commission, the local Health Systems Agency, the State Department of Health Facilities Licensing Section, or through the Annual Reports of Hospital to the Office of Statewide Health Planning Development.

#### Regulatory Assessment

The regulatory assessment will involve an analysis of the impact of laws and regulatory agencies on the operations and planning activity of the hospital. Laws such as the National Planning and Development Act (P.L. 93-641), California Certificate of Need Legislation (A.B. 4001), the California Administrative Code, and regulatory agencies including the Office of Statewide Health Planning and Development, and the Department of Health Services all exert significant impact of Medical Center of Tarzana's planning and decision-making process.

#### INTERNAL ASSESSMENT

In addition to compiling data necessary for analyzing and understanding the external variables affecting the hospital, a comprehensive and realistic internal assessment of Medical Center of Tarzana will also be undertaken. The internal assessment will require compilation and analysis of a variety of data descriptive of the institution, including hospital activity trends, medical staff data, and financial data.

### Hospital Activity Assessment

Probably the most valuable internal data regarding the hospital are those measures of its historical and current activity trends. It can be most enlightening to the Hospital Planning Committee and Board of Directors to display selected statistical measures of hospital activity over a three-year or five-year time base. The data used in Medical Center of Tarzana's planning and decision-making process will be compiled from a combination of hospital accounting records, patient medical records, and input from hospital department managers.

### Medical Staff Assessment

An accurate assessment of those physicians comprising the hospital's medical staff is vital to the planning and decision-making process. Data for this assessment will be derived from medical staff files and medical records and will include information regarding number of physicians by specialty, service utilization, and medical staff demographics. Additionally, a thorough assessment must solicit medical staff opinion of the facility and its future plans. Such opinions will be obtained through the use of a Physician Survey.

### Financial Assessment

The assessment of pertinent financial data is, in most cases, the major factor in decision making. Because of the extreme importance of financial data, complete accuracy is essential. Fortunately, the data needed in developing a financial assessment of a plan is easily

available and routinely kept in the form of various financial statements and statistical documents. These statements and documents are available from the hospital controller and are often reported to the state. While this data is readily available, often it is not compiled in a format which allows analysis of trends over time.

Medical Center of Tarzana financial data to be developed will include analysis of Balance Sheet and Income Statements, as well as Historical and Forecasted Service Net Income.

#### ANALYSIS OF DATA

Data, in and of itself, is useless to the Hospital Planning Committee and the governing body. A comprehension of the significance of trends depicted in the data and the analysis of these trends is necessary for effective planning and decision making.

#### EXTERNAL ANALYSIS

An analysis of those external variables affecting Medical Center of Tarzana will need to be conducted. The external variables to be considered will include the demographics of the population residing in the hospital's service area, utilization statistics of hospitals in competition with Medical Center of Tarzana, and an analysis of the laws and directives making up the regulatory environment in which the hospital exists. Each set of data pertaining to the external environment will be compared to published planning data, and numerous projections from the Los Angeles Department of City Planning, as well as United

States Census Data. Additionally, the Office of Statewide Health Planning and Development, the California *Administrative Code*, and the *National Guidelines for Health Planning* will be consulted and used to validate the data.

#### INTERNAL ANALYSIS

In addition to the external analysis, those internal data of the hospital will be analyzed. Those internal variables significant to Medical Center of Tarzana's planning and decision-making process will include historical and projected utilization statistics for overall admissions and patient days, as well as similar information for selected special hospital services; an analysis of the composition of Medical Center of Tarzana's medical staff, their practice expectations, and opinions regarding an expansion of the hospital; development of pro-forma ballance sheet and income statements at various levels of hospital occupancy, identification of income contributed by individual hospital services which will be affected by an expansion, and the development of pertinent financial ratios.

#### LIMITATIONS OF THE DATA

The data used in strategic planning and decision-making is subject to many limitations. These limitations can affect the reliability and long-term outcome of various planning alternatives.

A fundamental limitation is that strategic planning and decision making is an art and not a science. It is not

an exact process and there is not a 100 percent certainty of outcomes.

The data used in assessing Medical Center of Tarzana's external environment assessment is obtained from sources over which the hospital has little or no control. The demographic data, which is the basis of all utilization estimates, relies on population projections and demand estimates which are based on California Department of Finance figures. These figures are subject to interpretation. Additionally, the sample size used may not be truly representative of the hospital service area and there is a certain margin of error in converting census tracts to zip code areas and H.F.P.A. data. Finally, the Southern California population is extremely mobile and the demographics of the service area could change significantly over five or ten years.

Information on those hospitals Medical Center of Tarzana considers its competition is incomplete in some areas. Completely accurate service utilization data is not available from any public source. Additionally, service area figures and market capture of specific competing hospitals may only be available from individual hospitals themselves. Finally, possible "hidden agendas" and changing planning strategies of these institutions can have significant impact on Medical Center of Tarzana's future plans.

Current government regulation and reimbursement

formulas may change. The pro-forma financial analysis used in selecting alternatives is based on current formulas. If these formulas are reduced, the decreased level of reimbursement may jeopardize future profitability.

Finally, community values may change and increased community education or increased prenatal screening could result in fewer high-risk deliveries and lower intensive care newborn nursery utilization. Changing technology is not considered. Advances in medical technology could have significant impact on the design and delivery of tertiary services.



## Chapter 4

### RESULTS

### FINDINGS

This chapter discusses the results of the project. Chapter 2 develops and illustrates several examples of integrated planning and decision-making processes currently practiced in the field. Chapter 3 introduces those external and internal variables which impact on the Medical Center of Tarzana and those sources of data specific to each variable are identified. The purpose of this chapter is to present the findings, and in so doing, to demonstrate completion of each project objective.

#### OBJECTIVE 1

The first objective is "to describe in detail the actual planning and decision-making process followed by the Medical Center of Tarzana in the expansion of their Intensive Care Newborn Nursery (I.C.N.N.)."

The planning and decision-making process at the Medical Center of Tarzana began with the realization by hospital administration that the hospital was operating at high occupancy and could not accommodate additional patients. This situation was particularly evident in the

special service Intensive Care Newborn Nursery. A planning committee was formed, data was gathered and interpreted, planning alternatives were developed, and Board decisions were made regarding these alternatives.

#### Planning Committee Formation

Initial hospital planning efforts were primarily the responsibility of administration and the hospital's Director of Planning. Early efforts involved the preparation and keeping of historical utilization statistics. As the planning process became more sophisticated, and the need to make future utilization projections occurred, it became clear that input from other members of the hospital staff was necessary in the planning process. Thus, a loosely structured Planning Committee was formed.

The Medical Center of Tarzana's Planning Committee is a multi-disciplinary group comprised of hospital managers and chaired by the Director of Planning. Member participation varies depending on the focus of the planning effort and the frequency of meetings depends on the urgency to accomplish planning tasks. Only rarely does hospital administration, medical staff, or Board members attend or participate at Planning Committee meetings. Summaries of Planning Committee discussions and recommendations are prepared by the Director of Planning and communicated to hospital administration.

Addressing the Intensive Care Newborn Nursery

situation, the composition of the Planning Committee included the Director of Planning, the Medical Director, and the Nursing Supervisor of the Intensive Care Newborn Nursery, the Department Managers from Respiratory, Laboratory, and Social Service Departments, and the first-line supervisors from Respiratory and Nursing.

### Interpretation of the Data

Demographic Findings. A patient origin analysis was conducted using zip codes and is summarized in Appendix A. The patient origin analysis shows that almost 90 percent of Medical Center of Tarzana's patients came from a primary service area consisting of Health Facilities Planning Areas (H.F.P.A.) 903, 905, and 907 in Los Angeles County. Approximately 75 percent of the hospital's total patient days resulted from services provided to residents of the Van Nuys H.F.P.A. (905). The Service Area Map, Appendix B, shows the hospital's service area in relation to the rest of Los Angeles County and identifies the health facility planning areas (H.F.P.A.).

The Patient Origin Comparison, Appendix C, illustrates the origin of patients using various services. Intensive care newborn nursery patients, newborn nursery patients, perinatal patients, and pediatric patients are compared. The appendix shows that the hospital is a significant provider of services to newborns and children. Particularly important is the fact that half of the

intensive care newborn nursery patients came from H.F.P.A. 905 and that admissions from this area are increasing.

Population data showing the rapid rate of growth within the primary service area between 1978 and 1985 appears in Appendix D. This data shows that the population in both the San Fernando and Van Nuys H.F.P.A.'s is expected to increase one percent or more per year, a rate which is higher than the projected county rate of 0.6 percent. Also, overall Los Angeles County growth is about one percent below the state's projected annual rate of increase which is 1.7 percent.

According to the Los Angeles Department of City Planning, by 1990 the total population projected to be located in Medical Center of Tarzana's service area will be 783,000. The service area is projected to increase by 70,722 in the 1980 to 1990 period, which represents a 1.1 percent annual rate of population growth. It is interesting to note that Los Angeles County is projected to experience a 0.6 percent annual growth rate, while California is expected to experience a 1.7 percent annual rate of growth, which is comparable to the national rate during the past decade of about one percent per year.

The socioeconomic profile in Appendix E shows that the percentage of population with income below \$7,000 a year ranged from 18 percent in H.F.P.A. 903 to almost 21 percent in H.F.P.A. 907. This is interesting when compared to other data regarding select areas of the

hospital's service area. For instance, in the Encino-Tarzana community where the hospital is located, more than 34 percent of the population have had some college education, and better than 60 percent are employed in white collar positions. The average family income is \$31,000 and the average home costs in excess of \$300,000.

Hospital Competition Findings. An analysis of those hospitals in the Medical Center of Tarzana's service area was also conducted. The data in Appendix F identifies six hospitals which surround the Medical Center of Tarzana as primary competitors. This determination was made based on whether the community where the competitive hospital is situated contributed at least 2 percent of admissions to Tarzana, or the hospital was repeatedly mentioned by the physician staff through either the written survey administered by the hospital or the interviews conducted.

In 1979 the Medical Center of Tarzana had the highest percentage of occupancy (81%) and the lowest average length of stay of all the hospitals in the service area, while five hospitals experienced occupancies of less than 50 percent. The two largest competitors, Northridge Hospital and Valley Presbyterian Hospital, experienced occupancies of 71 percent and 60 percent respectively.

A comparison of the patient day data in 1973 and 1979 indicates that of all the hospitals located in the same area, only the Medical Center of Tarzana and Northridge Hospital had experienced an increase in total patient days.

This is a significant finding since Northridge Hospital and the Medical Center of Tarzana are considered the premier hospitals in the San Fernando Valley, and therefore indicates that demand exists for high-quality hospital beds, and not just additional inpatient capacity.

A map of the service area and the location of the hospital competition is found in Appendix G.

The Medical Center of Tarzana is one of the largest providers of perinatal services in the service area (H.F.P.A.s 903, 905, and 907). Utilization data for 1976 through 1978 shows that the Medical Center of Tarzana was second only to Kaiser Hospital of Panorama City in providing perinatal services. Appendix H shows that the Medical Center of Tarzana had 7,078 perinatal patient days in 1978, Kaiser had 12,050, and Valley Presbyterian had 4,853. Intensive Care Newborn Nursery and perinatal service providers located near Medical Center of Tarzana are shown in Appendix I.

Regulatory Findings. Corporate legal and planning staff were the primary participants in the regulatory analysis. The approved Los Angeles County *Health Systems Plan* for 1980 identifies an excess of acute medical/surgical beds in the Medical Center of Tarzana's service area. It also identifies a need for 23 additional I.C.N.N. basinetts by 1985 for the Health Services Area (Los Angeles County), and recommends granting certificates of need for additional I.C.N.N. basinetts. The draft *Health Systems*

*Plan* for 1981 identifies a need for 133 or 143 additional I.C.N.N. basinet, depending on the bed need methodology used. Under recommended actions the *Plan* states:

. . . the Office of Statewide Health Planning and Development and the area agency consider granting Certificates of Need for additional ICNN basinet to meet the resource requirement shortages identified in facilities currently demonstrating high occupancy rates and primarily serving Med-Cal eligible or other populations with high-risk characteristics.

Appendix J contains a table from the Los Angeles *Health Systems Plan* showing existing and projected I.C.N.N. basinet need. The draft *Plan*, which recognizes only licensed basinet, shows 164 existing I.C.N.N. basinet, less than the approved *plan*, which has counted "set-up," but unlicensed beds as well as licensed ones. The Medical Center of Tarzana's existing intensive care newborn nursery meets the state's requirements for operation. The unit is not in compliance with the *Federal Planning Guidelines* for intensive care newborn nurseries which recommend a 15-bed unit as minimal size (Appendix K).

Utilization Findings. The Medical Center of Tarzana has operated at a near capacity level since 1973. Data displayed in Appendix L shows that the hospital has operated in excess of 85 percent occupancy since 1977. This appendix also shows projected utilization to continue at 35,600 patient days annually, or 87 percent occupancy.

An analysis of selected program utilization, Appendix M, shows that projected demand for perinatal and

intensive care newborn nursery services will maintain high levels of utilization. Historical and projected utilization, supported by an increasing population, demonstrates that perinatal services will reach 8,000 patient days and 81.2 percent occupancy level during 1982 and maintain that occupancy thereafter. I.C.N.N. utilization is expected to reach 4,653 patient days and an 85 percent occupancy by 1985, based on a 15-basinet unit operation by January 1984. The unit is expected to plateau at 4,930 patient days and 90 percent occupancy by 1986.

Appendices N and O display projected deliveries at the Medical Center of Tarzana. The data suggest over 2,800 deliveries, including 700 cesarean sections annually by 1985.

Medical Staff Findings. An assessment of the medical staff opinion of the hospital planning efforts was conducted using a Physician Survey displayed in Appendix P. An analysis of the data obtained from the survey is displayed in Appendix Q. The data shows that about half the physician respondents indicated that they expect their practices to increase over the next five years. It is significant to note that not one physician indicated his practice would decline during the next five years. Additionally, the overwhelming opinion of the physicians responding was that expansion was needed and overdue, while only 25 percent indicated that an expansion at Tarzana would adversely impact other San Fernando Valley



hospitals.

A profile of the Medical Center of Tarzana's medical staff, Appendix R, shows a total medical staff of 643 physicians of whom 175 have active privileges. The current medical staff includes 56 specialists in OB/GYN (23 active) and 75 pediatricians (30 active), including two neonatologists.

Financial Findings. The analysis of financial data was conducted primarily by corporate financial staff with the assistance of hospital administration. The balance sheet analysis, Appendix S, and the income statement analysis, Appendix T, indicate the Medical Center of Tarzana enjoys a strong financial position. The current ratio and acid test ratio demonstrate positive trends. Government insured program patients remain fairly constant at 9 percent of total revenue. Operating margin is very satisfactory in relation to the industry. Appendix U displays income contributed by the intensive care newborn nursery, the clinical laboratory, and respiratory therapy. These data are necessary when developing pro-forma profitability analyses of the planning alternatives.

#### Development of Planning Alternatives

The Hospital Planning Committee has a thorough understanding of Medical Center of Tarzana's mission ". . . to provide facilities for the provision of acute medical services, diagnosis and treatment. . . ." and the hospital's

goals to provide for ". . . state-of-the-art equipment and facilities . . . which will grow to meet the needs of the service area. . . ." Given this understanding of the mission and goals, and using the data compiled, the planning committee developed possible expansion alternatives to be considered. It is at this point that corporate legal, financial, and planning staff become actively involved in the planning portion of the planning and decision-making process.

The committee emphasis, when developing alternatives, was not to scrupulously analyze each bit of data and design the perfect strategic plan. Rather, the committee was asked to understand the data and trends in a broad sense and develop many alternatives, some optimizing, others more adaptivizing. The main factors influencing the development of alternatives were: the positive hospital occupancy trend and projected increased population growth in the service area; the constraints of existing structures and available property on which to build; and the constraints imposed by regulation, i.e., the *Health Systems Plan*. So as not to eliminate any options, the committee did not consider the financial impact of the alternatives. It was felt that a thorough financial analysis of each alternative should be conducted by those most skilled in the analysis, the corporate financial staff.

Five expansion alternatives were developed (Appendix V). These alternatives ranged from the Medical Center of

Tarzana's present 200-bed capacity to a minimum of 212 beds, Alternative 5, up to a maximum of 356 beds, Alternative 3. The total estimated construction costs of each alternative range from \$2.5 million for Alternative 5, up to \$26.5 million for Alternative 3.

#### Board of Directors Reaction to Alternatives

The five planning alternatives were presented to the Board of Directors of the Medical Center of Tarzana at their regularly scheduled board meeting. Each alternative was explained by the Director of Planning and the Board was encouraged to ask questions and provide input. The Board as a whole was too diverse and lacked the necessary expertise to make any formal decision regarding the alternatives. Key members of the Board were charged to work with hospital administration, corporate planning, financial, and legal consultants, to gain Corporate Finance Committee input and undertake the process of selecting from the five alternatives.

According to the Board, primary considerations which form the framework in which Medical Center of Tarzana is to exist are:

1. A positive utilization trend and anticipated service area population growth;
2. The significance of special permit services such as perinatal and intensive care newborn nursery services;
3. The *Health System Plan* which identifies an excess of acute medical-surgical beds but a shortage of intensive care newborn nursery beds;

4. A hospital medical staff supportive of a hospital expansion;
5. And, pro-forma profitability statements, Appendix W, which indicate that the expansion of the Medical Center of Tarzana would be profitable.

The special adhoc committee spent several months evaluating each of the five alternatives. Often the Planning Committee was asked to provide additional data or to comment on revised projections. Many confidential meetings were held during the long selection process. The length of time the Planning Committee's alternatives were "held at Corporate" was often discouraging not only to the Committee, but to hospital administration as well.

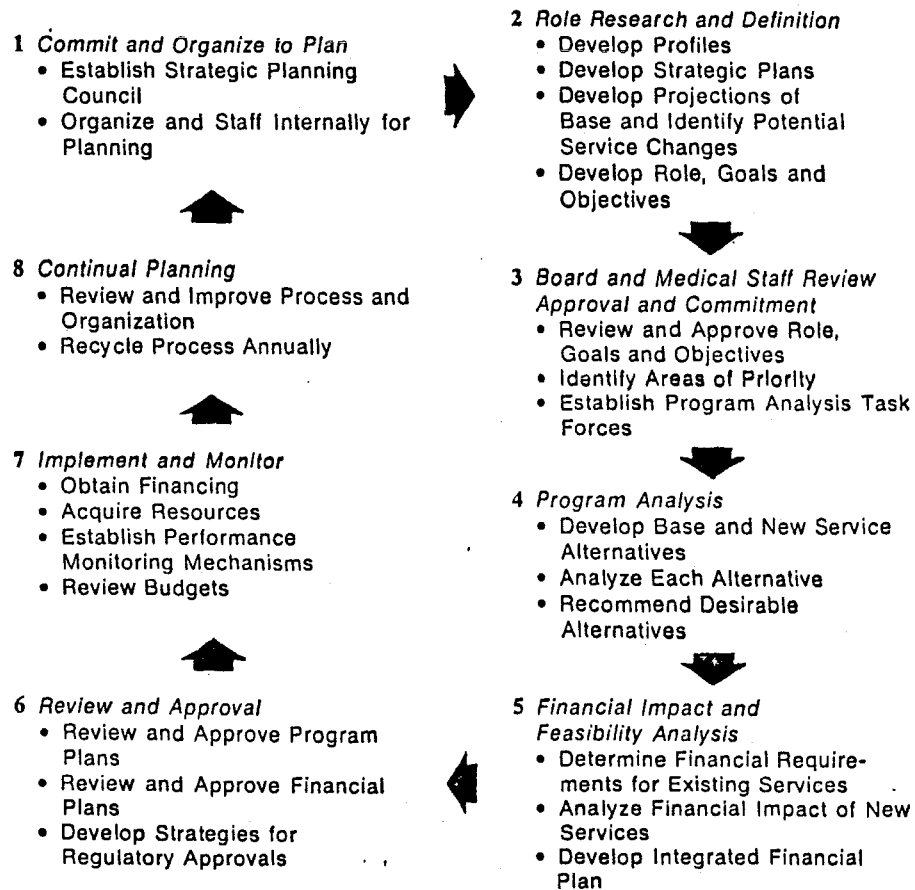
#### OBJECTIVE 2

The second objective is "to compare the actual planning and decision-making process at the Medical Center of Tarzana with its formal published process and to existing planning and decision-making models."

Figure 1 displays the formal planning and decision-making process and appears in the Medical Center of Tarzana's *Management Training Manual*. The figure summarizes an ideal ongoing planning and decision-making activity involving department managers, hospital administration, medical staff, and members of the board. It combines organized hospital planning and decision-making activities with Management by Objectives, hospital budget preparation and justification, and performance review. The

FIGURE 1

**MEDICAL CENTER OF TARZANA  
PLANNING AND DECISION MAKING PROCESS**



Source: Medical Center of Tarzana's *Management Training Manual*.

hospital's formal budget process is flow charted in more detail in Appendix X.

The planning and decision-making process shown in Figure 1 begins with a formal commitment to planning at all levels of the hospital organization. This commitment requires the staffing necessary to carry out the rest of the process. Long-range plans based on corporate, hospital, and departmental financial and utilization projections are developed and integrated into the overall hospital strategic plan. Goals and objectives are developed at departmental levels and for the hospital overall. A review process follows which involves all levels of hospital management, hospital medical staff, board, and corporate staff. This review is primarily financial in nature, but also insures that each level of management has developed projections and plans which support the next higher level in the organization. Ultimately the hospital's strategic plan is incorporated into the strategic plan of the corporation. These plans are implemented and performance monitoring completes the loop.

The actual process followed at the Medical Center of Tarzana during their expansion efforts is not as integrated and clearly defined as the formal process just described. The major thrust of the actual planning and decision-making process at the hospital level is limited to facilities expansion. Overall, the actual process appears to be a rather informal and disorganized activity

conducted to justify prior administrative decisions to expand hospital services.

A capital budget review was conducted by corporate financial staff to determine the financial soundness of the plan, but the other elements of the Medical Center of Tarzana's formal process are only slightly integrated into the actual process. Most obviously absent is the additional program development necessary to achieve the high utilization used in determining the financial soundness of the plan. Additionally, a broad base of management and medical staff input to the planning process is lacking.

To compare the Medical Center of Tarzana process with the planning and decision-making models currently practiced in the field, one must first realize that the Medical Center of Tarzana is part of a proprietary hospital system comprised of over sixty facilities. As part of this system, the Medical Center of Tarzana must deal with a greater diversity of participants and closer financial scrutiny. The hospital must be sensitive to the goals and financial requirements of the system as a whole. Being part of this system requires that planning and decision making occur at two levels, the hospital level and the corporate level.

The literature identifies three generic systems planning models. The major difference between these models is the corporate perspective of each hospital within the system. The process followed by the Medical Center of

Tarzana is very similar to the cooperative planning model displayed in Table 3 of Chapter 2.

The cooperative model represents a planning and decision-making process which is initiated simultaneously at the hospital and corporate levels. During the Medical Center of Tarzana's process, initial efforts to expand the facility were initiated by the hospital, but the strategic implications of the expansion and the development of a long-range strategic plan were coordinated by corporate planning and financial consultants. Hospital administration tended to focus more on the short-term result of their efforts, i.e., the Intensive Care Newborn Nursery expansion, while corporate staff were more concerned with long-term viability and the development of a Long-Range Strategic Plan.

While the cooperative model can be compared to the actual expansion process followed by the Medical Center of Tarzana, the similarities are even greater when comparing the model to the hospital's formal published planning and decision-making process. Both the cooperative model and the formal process depict a supportive process where opportunities are mutually identified by hospital and corporate staff. The hospital's plans and budgets exist within certain corporate parameters, but include certain independent initiatives as well. Finally, the corporate strategic plan and budget are the consolidation of individual hospital plans and budgets.



The actual process, in contrast, tended to be more corporate directed with greater centralization and "top-down" decision making. Frequently corporate planning and financial consulting staff outnumbered hospital staff at meetings and at times intimidated hospital personnel.

### OBJECTIVE 3

The third objective is "to analyze the planning and decision-making process with respect to its impact on the overall development of the hospital."

The Medical Center of Tarzana experienced both short-term and long-term benefits from the planning and decision-making process as it occurred. The hospital Planning Committee, and hospital administration to a lesser extent, was expecting corporate approval of a limited intensive care newborn nursery and ancillary department expansion program. What eventually transpired was the Board of Directors' approval of a 20-year Master Facility Plan (Appendix Y). This plan incorporates Alternative 5 and Alternative 3 into a three-phase strategy which will eventually increase the Medical Center of Tarzana's bed capacity to 356 beds by the late 1980's.

Addressing the immediate shortage of intensive care newborn nursery beds in the Medical Center of Tarzana's service area, the Board capitalized on the opportunity and resolved (Appendix Z) to fund the immediate expansion of the hospital's three-bed unit up to a capacity of 15 beds.

The expansion of the Respiratory, Laboratory, and Social Service Departments was also approved.

#### OBJECTIVE 4

The fourth objective is "to make recommendations regarding the planning and decision-making process at the Medical Center of Tarzana which will enable their future efforts to be carried out in a more effective manner."

After conducting a thorough review of the literature, studying various strategic planning and decision-making models, and having been involved in the actual planning and decision-making process at a hospital, the author is prepared to make the following recommendations. These recommendations were developed during an informal group discussion with the author, hospital administration, corporate planning staff, and members of the hospital board.

The hospital planning committee should be continued and expanded to include increased representation of the medical staff and community. Additionally, the position of Director of Planning should be maintained in the hospital's organizational structure.

The hospital's mission and strategic planning options should be periodically reviewed and validated by the hospital board, medical staff, administration, and department managers. Further, department managers should be encouraged to increase their planning input and be more

future oriented.

Hospital administration, board members, and department managers should be encouraged and given the time to discuss trends and future plans with their counterparts at neighboring institutions. Such an exchange of ideas will help to strengthen the planning process. Hospital administration and members of the board might consider the possibility of forming some type of inter-hospital planning group to discuss common planning issues.

Medical Center of Tarzana's parent corporation should explore and encourage increased joint planning between system hospitals serving the same or similar service areas.

Those involved in the coordination of the planning process should understand the management, governing, and practice styles of hospital administration, board of directors, and medical staff respectively. The amount and detail of data and the length of time spent discussing such data should be geared in accordance with the inclinations and needs of those involved.

Shortening the decision-making process might be considered by consolidating or eliminating some of the corporate staff review functions.

Finally, at the hospital level, administration, department managers, medical staff, and members of the board would benefit by increasing their understanding of the planning and decision-making process. At the corporate level, the formal publicized planning and decision-making

process should be reviewed to ensure that it accurately depicts the process the corporation follows.

## Chapter 5

### CONCLUSION, RECOMMENDATIONS, AND SUMMARY

#### CONCLUSION

The Medical Center of Tarzana and the community will benefit from the activities followed during the hospital's expansion efforts. The expanded Intensive Care Newborn Nursery is clearly needed in the service area and the development of the 20-Year Master Plan should help to focus the Medical Center of Tarzana's planning efforts and give direction to future program development.

In reviewing the process, the Medical Center of Tarzana followed to develop the expanded Intensive Care Newborn Nursery formal planning and decision making, as discussed in this project, was not followed. The generation and analysis of data, meetings with the Board, and involvement of other groups was all done "after the fact." These actions took place after hospital administration had already personally decided to expand the unit. The data and the meetings were conducted primarily to justify administration's decision and to gain corporate approval necessary to fund the expansion.

The development and adoption of the 20-Year Master Plan comes closer to formal planning and decision making.

The development and analysis of data, the assessment of the strengths and weaknesses of the facility, and the development of future projections utilized the expertise of many groups' hospital administration, planners, medical staff, legal and financial consultants. The 20-Year Plan, coordinated at the corporate level, serves as a guide for the hospital's future planning efforts, and allows the corporation to prepare for future resource allocations.

#### RECOMMENDATIONS

In today's regulatory climate, health care institutions must address costs, financing, and reimbursement issues to maintain their long-term viability. Strategic planning and decision making is more than a set of tasks that integrate hospital activities with their future environment; it is a way of thinking. Those institutions which do not attempt to control their responses to the external and internal forces expected in the future will become victims of the changes that occur, rather than their masters.

The means to control the hospital's response to its environment are known. It is essential to coordinate the financial control elements of management into an ongoing planning and decision-making process. Only through experience in the use of an integrated process will hospitals optimize their future positions. With the difficulties of providing high-quality health services at

reasonable cost, the challenge is to develop and apply effective strategic planning and decision-making process in each hospital.

A review of strategic planning and decision making in the future will show that hospitals will vary in the level of sophistication of their planning and decision-making process. Some institutions, suffering from arrested development, will consider facilities planning both the beginning and the end of their needs. Other institutions will lack the necessary frameworks for choosing among alternatives generated by their institutional planning systems. The pioneers in the field of strategic planning and decision making will have learned to deal with their current environments by adopting progressive, rational processes, enabling them to embrace the issues of significance affecting the future of health care.

Understanding that the process of hospital planning and decision making is a skill which needs to be practiced to become effective, the following general recommendations might be applied to any hospital setting.

The organization at all levels must make a commitment to plan. This commitment is founded on the belief that an organization can directly impact its future by its decisions today.

The planning activity must be linked to other management functions and have a defined structure involving some type of planning team or committee. This committee should

be multi-disciplinary in nature and involve administration, the board, the medical staff, hospital department managers as necessary, and corporate representatives.

Those involved in the planning and decision-making process should be given adequate time and staff support. The development of a position of Planner is strongly recommended. This person will have the expertise necessary to coordinate the actions of many groups, facilitate the gathering of planning data, and help to ensure that the process is ongoing.

#### SUMMARY

This paper examines an integrated strategic planning and decision-making process and its application in a hospital setting. Various planning and decision models are presented and their significant principles are discussed. The methodology followed in developing this project is described in Chapter 3. Chapter 3, in the section entitled "Sources of Data and Their Measurement," describes the sources of data necessary for planning and categorizes these data into external and internal groups.

Chapter 4 presents the results of the project. Significant findings are:

1. The formation of the Planning Committee;
2. Interpretation of the planning data;
3. Development of planning alternatives;
4. Board of Directors' reactions to the planning



alternatives;

5. Adoption of a 20-Year Master Plan;
6. A description of the strategic planning and decision making process;
7. Recommendations to the Board regarding the Medical Center of Tarzana's planning and decision-making process.

Chapter 4 also identifies those issues the hospital governing board considered significant in their selection of the planning alternatives. These issues include:

1. A positive utilization trend and anticipated service area population growth.
2. The significance of special permit services such as perinatal and intensive care newborn nursery services.
3. The *Health System Plan* which identifies an excess of acute medical-surgical beds, but a shortage of intensive care newborn nursery beds.
4. A hospital medical staff supportive of a hospital expansion.
5. Pro-forma profitability statements which indicate that the expansion would be profitable.

The project is concluded with Chapter 5, where recommendations are presented regarding the strategic planning and decision-making process, which might be applied in other hospital settings.

Issues which warrant future study would include follow-up regarding the accuracy of the utilization data and financial projections, and monitoring during the implementation of Phase III of the hospital's Master Plan to see if the author's recommendations are correct.

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APPENDICES

## APPENDIX A

## Medical Center of Tarzana

TOTAL HOSPITAL PATIENT ORIGIN  
PERCENT PATIENTS AND PATIENT DAYS  
1977-1979

Area	HFPA	Patients			Patient Days		
		1977	1978	1979	1977	1978	1979
San Fernando	903	8.1	8.3	7.4	7.5	7.3	7.0
Van Nuys	905	73.3	72.9	73.7	73.9	75.0	75.3
Burbank	907	7.6	7.4	7.6	8.4	7.4	7.0
Sub-total		89.0	88.6	88.7	89.8	89.7	89.3
Other		10.9	11.3	11.4	10.1	10.2	10.7
Totals*		99.9	99.9	100.1	99.9	99.9	100.0
Number		12,300	11,756	11,665	70,171	58,651	60,501
Percent Change			-4.4%	-0.7%		-16.4%	-3.1%

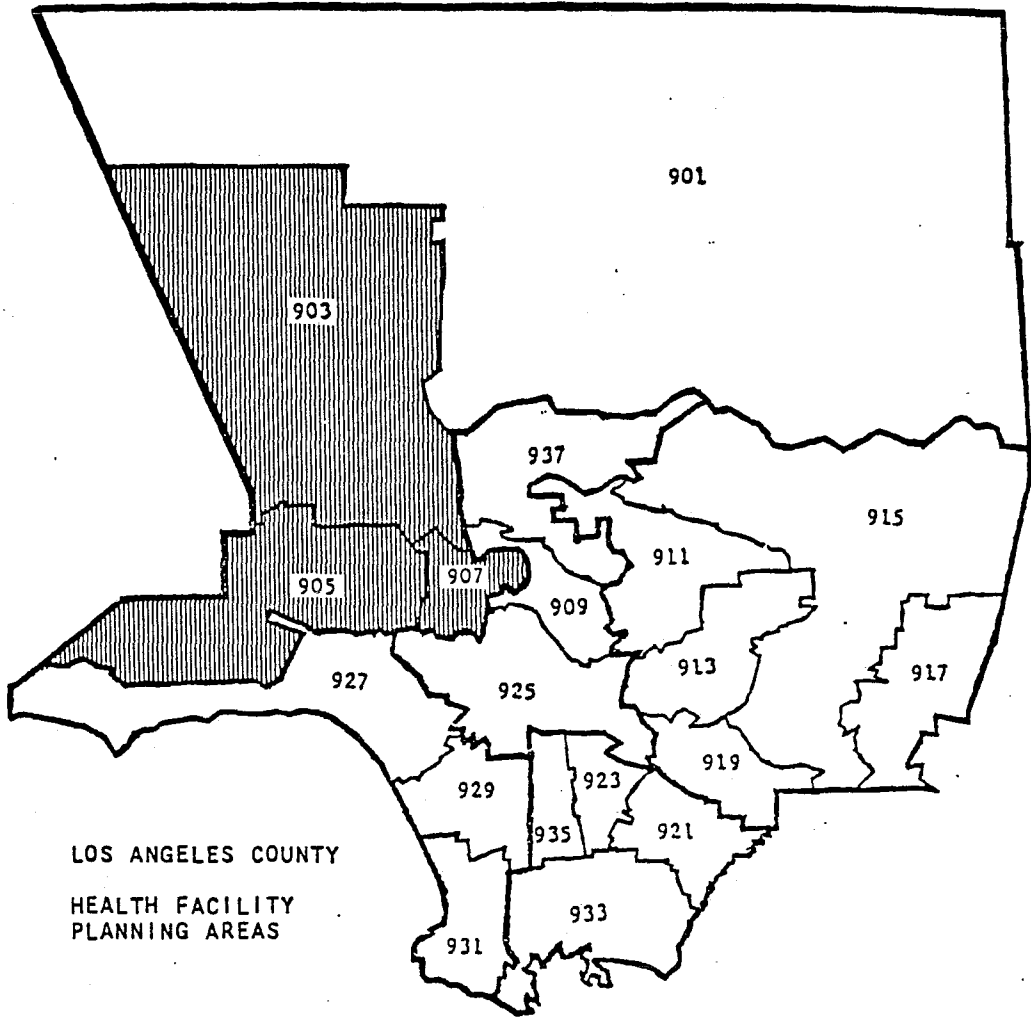
Note: \* Totals may not equal 100.0% due to rounding.

Source: Hospital Patient Origin Records, and Annual Reports, 1977-1979.

APPENDIX B

Medical Center of Tarzana

SERVICE AREA MAP



## APPENDIX C

## Medical Center of Tarzana

PATIENT ORIGIN COMPARISON  
 PERCENT PATIENTS TOTAL HOSPITAL AND ICNN PATIENTS  
 1978-1979

Area	HFPA	1978		1979	
		Total	ICNN	Total	ICNN
<b>Primary Service</b>					
San Fernando	903	8.3	23.8	7.4	26.2
Van Nuys	905	72.9	57.1	73.7	50.0
Burbank	907	7.4	9.5	7.6	7.5
Sub-total		88.6	90.4	88.7	83.7
<b>Other HSA 11</b>					
Los Angeles County		6.4	7.1	6.0	7.4
Ventura County		3.7	2.4	3.6	7.5
Other		1.2	0.0	1.8	1.3
Sub-total		11.3	9.5	11.4	16.2
Totals		99.9	99.9	100.1	99.9
Number		11,756	42	11,665	80

Note: Totals may not equal 100.0% due to rounding.

Source: Hospital Patient Origin Records.

## APPENDIX D

## Medical Center of Tarzana

TOTAL POPULATION OF PRIMARY SERVICE AREA,  
LOS ANGELES COUNTY, AND STATE  
1978 - 1985

Area	(HFPA)	1978	1985	Annual Rate of Change
-----	-----	-----	-----	-----
San Fernando	(903)	284,500	306,800	1.1%
Van Nuys	(905)	600,800	643,400	1.0%
Burbank	(907)	261,800	270,300	0.5%
LA County		7,076,600	7,358,900	0.6%
California		22,004,945	24,605,544	1.7%

Source: OSHPD, Publication P193, 5/21/80.

Medical Center of Tarzana

PERINATAL PATIENT ORIGIN  
PERCENT PATIENTS AND PATIENT DAYS  
1978-1979

Area	HFPA	Patients		Patient Days	
		1978	1979	1978	1979
San Fernando	903	9.0	9.9	11.4	9.6
Van Nuys	905	70.4	68.8	68.5	69.8
Burbank	907	8.5	8.8	8.5	8.6
Other		12.1	12.5	11.6	12.0
Totals		100.0	100.0	100.0	100.0
Number		2,439	2,491	7,064	7,616
Percent Change			2.1%		7.8%

Source: Hospital Patient Origin Records.

Medical Center of Tarzana

NEWBORN PATIENT ORIGIN  
PERCENT PATIENTS AND PATIENT DAYS  
1978-1979

Area	HFPA	Patients		Patient Days	
		1978	1979	1978	1979
San Fernando	903	10.7	9.8	10.3	11.0
Van Nuys	905	69.1	69.5	69.9	69.0
Burbank	907	8.8	8.8	8.5	9.1
Other		11.3	11.9	11.3	10.8
Totals		99.9	100.0	100.0	99.9
Number		1,831	2,049	5,610	7,170
Percent Change			11.9%		27.8%

Note: Totals may not equal 100.0% due to rounding.

Source: Hospital Patient Origin Records.

Medical Center of Tarzana

PEDIATRIC PATIENT ORIGIN  
PERCENT PATIENTS AND PATIENT DAYS  
1978-1979

Area	HFPA	Patients		Patient Days	
		1978	1979	1978	1979
San Fernando	903	11.3	12.0	16.5	13.1
Van Nuys	905	70.3	71.2	63.9	66.9
Burbank	907	9.4	6.9	8.5	7.0
Other		9.0	9.9	11.1	13.0
Totals		100.0	100.0	100.0	100.0
Number		1,229	1,116	3,960	3,668
Percent Change			-9.2%		-7.4%

Source: Hospital Patient Origin Records.



## APPENDIX E

## Medical Center of Tarzana

SOCIO-ECONOMIC PROFILE OF PRIMARY SERVICE AREA  
1976

Percent of Ethnic Distribution	HSPA			HSA 11
	903	905	927	LA County
White*	69.0 %	86.2 %	82.9 %	71.9 %
Mexican-American	24.0 %	12.1 %	16.0 %	17.6 %
Black	7.0 %	1.7 %	1.1 %	10.6 %
<b>Socio-Economic Indicators</b>				
With Professional Occupation	15.8 %	22.5 %	18.4 %	15.5 %
With Income under \$7,000	18.3 %	16.8 %	20.9 %	26.3 %
With High School Education	63.3 %	74.9 %	66.8 %	62.0 %
Area Population	283,764	598,948	262,544	7,093,048

Note: \* Includes Caucasian and those groups not classified Black or Mexican American.

Source: Health Services Plan, Los Angeles County  
March 1980, Pages 14-15

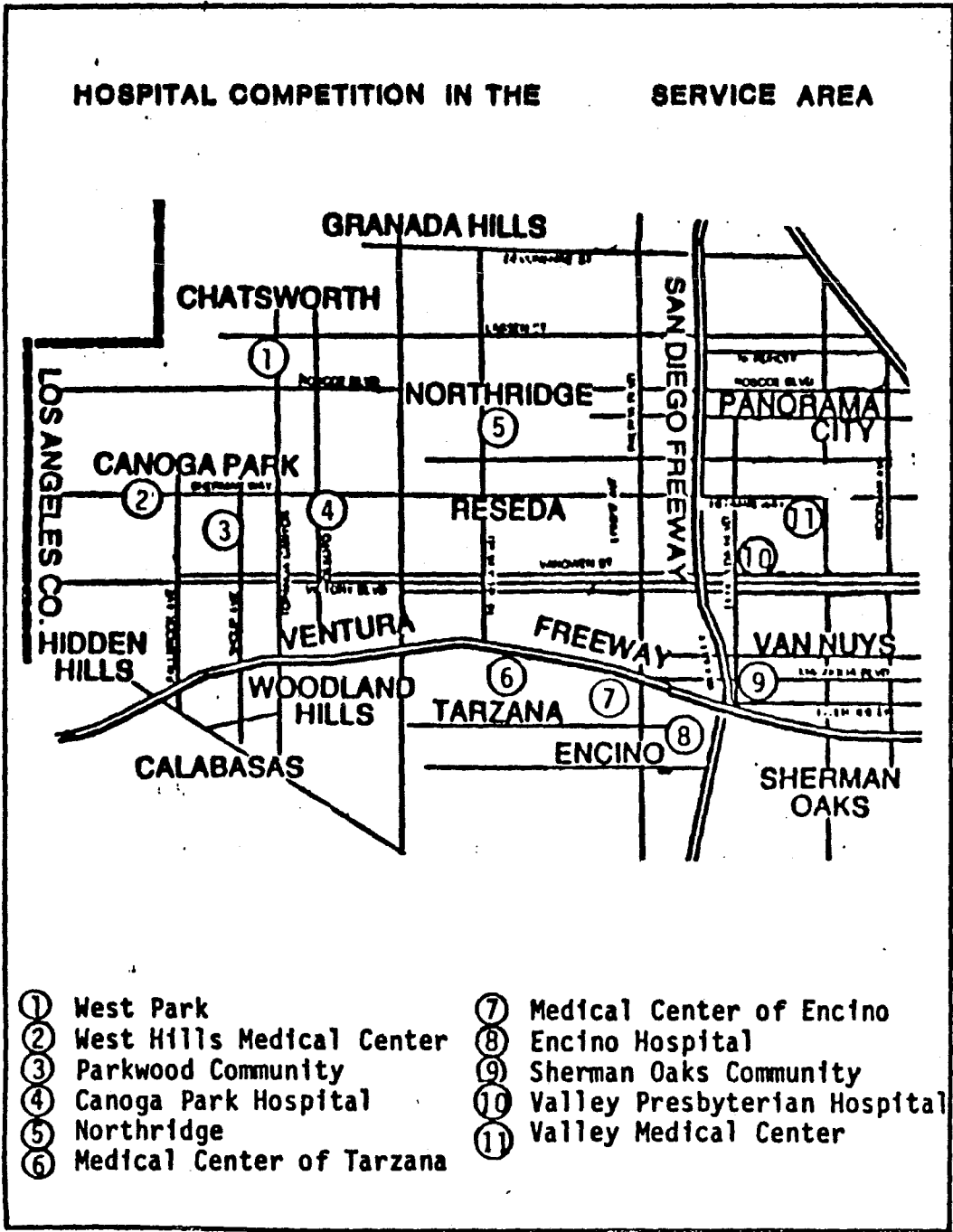
## APPENDIX F

## HOSPITAL COMPETITION

Hospital	Licensed Beds	Occupancy 1979	Patient Days	ALOS	Licensed Beds	Occupancy 1977	Patient Days	ALOS	Licensed Beds	Occupancy 1973	Patient Days	ALOS
Medical Center Tarzana	200	81%	59,433	5.0	200	82%	60,086	5.0	Not Opened			NA
Medical Center of Encino	146	46%	24,438	8.6	146	22%	11,563	5.0	152	48%	28,105	NA
West Park Hospital	139	44%	14,780	6.3	139	47%	24,034	2.2	139	55%	26,645	NA
West Hills Medical Center	236	45%	26,027	5.7	236	36%	31,200	5.7	116	69%	29,200	NA
Parkwood Community	112	48%	19,524	6.9	112	45%	18,543	7.3	112	34%	13,870	NA
Canoga Park Hospital	72	62%	16,221	6.4	72	63%	16,484	6.0	72	76%	20,075	NA
Northridge Hospital Foundation	319	71%	83,229	8.8	269	66%	64,813	8.1	219	67%	52,925	NA
Valley Medical Center	178	25%	9,490	NA	213	25%	19,669	6.6	66	NA	NA	NA
Valley Presbyterian Hospital	363	60%	78,903	6.0	363	58%	76,446	6.1	289	76.1%	80,300	NA
Encino Hospital	189	58%	39,969	6.7	189	51%	35,003	6.7	164	68%	40,515	NA
Sherman Oaks	141	58%	19,771	6.1	141	56%	28,585	6.5	141	53%	29,565	NA

SOURCES: California Health Facilities Commission for 1979, and 1977  
American Hospital Association Guide to the Health Care Field 1973

APPENDIX G



## APPENDIX H

## Medical Center of Tarzana

AREA PERINATAL SERVICE UTILIZATION  
1976-1978

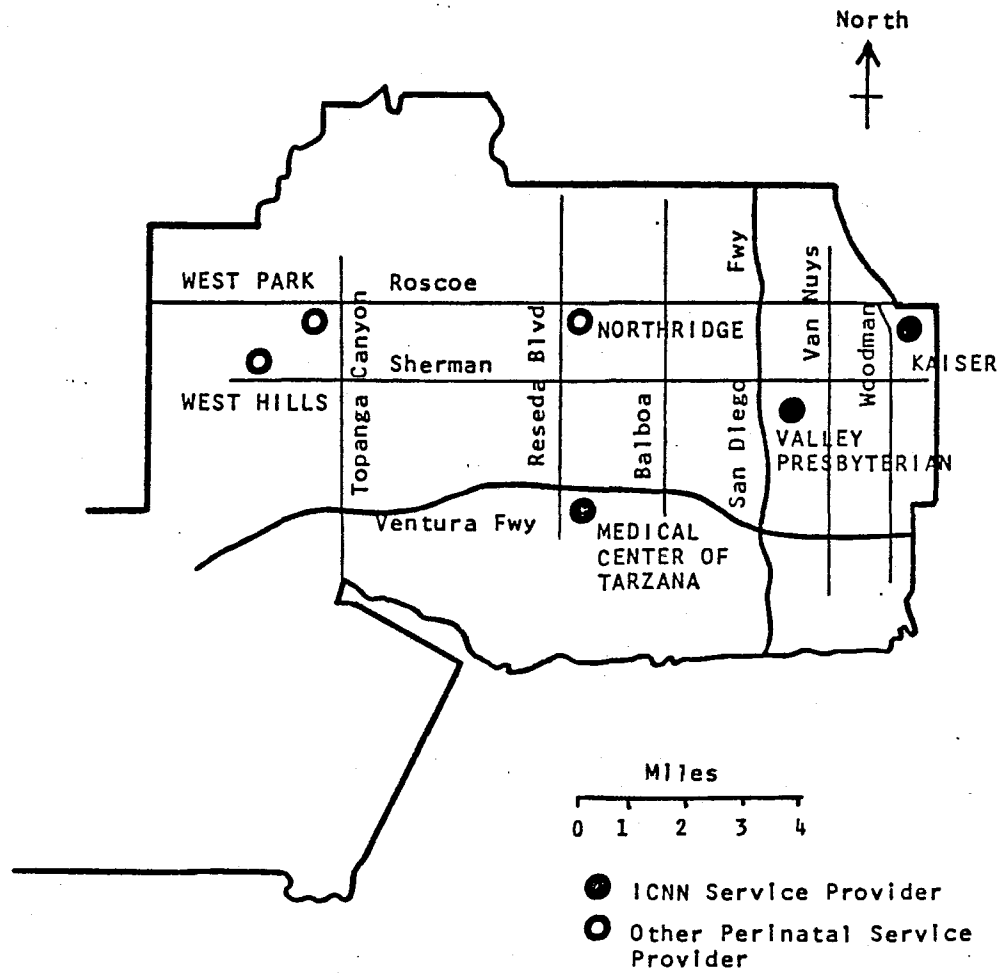
Area and Facility	1976		1977		1978		B L E I D C S
	Pts	Pt Day	Pts	Pt Day	Pts	Pt Day	
<b>San Fernando (903)</b>							
Comm Hosp							
Granada Hills	1495	4156	1427	3976	1112	3052	16
Newhall Mem Hosp	443	1072	439	745	650	828	11
Lutheran Hosp	953	2293	644	1543	546	1458	10
Holy Cross	-	-	386	1095	895	2155	14
	2891	7521	2896	7359	3203	7493	51
<b>Van Nuys (905)</b>							
Kaiser- Panorama	3516	12304	3484	12042	3625*	12050	41
Medical Ctr Tarzana	2367	7433	2424	8530	2327	7078	27
Northridge	780	2110	1051	2877	1186*	3200	13
Valley Presbyterian	1443	4049	1757	4917	1642	4853	28
West Hills	-	-	472	1347	587	1700	10
West Park	-	-	477	931	537	1094	15
Westlake Comm	-	-	600	1783	785	2476	12
	8106	25896	10265	32377	10689	32451	146
<b>Burbank (907)</b>							
Burbank Comm	392	1087	394	1060	325	961	7
Riverside Hosp	666	1760	414	1207	468	1394	10
Sierra Mem	1621	4202	1601	4322	1728	4362	16
St. Josephs	838	2761	900	2829	878	2869	23
	3517	9810	3309	9418	3399	9586	56
<b>Service Area Totals</b>	<b>14514</b>	<b>43227</b>	<b>16470</b>	<b>49154</b>	<b>14088</b>	<b>49530</b>	<b>253</b>
% Change in Pts			13.5%		-14.5%		
% Change in Pt Days				13.7%		0.8%	

Sources: 1976 - 1978 LA County HSP  
1977 - 1980 LA County HSP Data Compendium  
1978 - OSHPD Publication UH 538(78B)  
\* Corrected per audited Annual Report

APPENDIX I

Medical Center of Tarzana

ICNN AND OTHER PERINATAL PROVIDERS  
VAN NUYS AREA (HFPA 905)



## APPENDIX J

## Medical Center of Tarzana

NEONATAL INTENSIVE CARE BED NEED  
1985

Plan	Licensed Beds	Needed In 1985	1985 New Beds Needed
Approved LA County 1979-1985	249	272	23
Draft LA County 1980-1985			
Method 1	164	297	133
Method 2	164	307	143

Note: The approved plan for 1979-1985 includes set-up but not licensed beds(bassinets). The draft 1980-1985 plan reflects only licensed beds.

- Sources: 1. Area Health Facilities and Services Plan, Los Angeles County, March 1980 OSHPD, Page 287.
2. Area Health Facilities and Services Plan, Los Angeles County, May 28, 1980 OSHPD, Pages 290-291.

## APPENDIX K

NATIONAL GUIDELINES FOR HEALTH PLANNING

HEW, MARCH 1978

health professionals and consumers, (3) transport of selected patients to facilities possessing more specialized maternal and neonatal services, (4) a continuing evaluation of the effectiveness and costs of regionalized programs.

In 1972 the American College of Obstetrics and Gynecology identified a minimal target of 1,500 births per year for facilities in communities of 100,000 population or more to provide a full range of obstetrical services in an efficient manner. In 1974, this figure was revised: "The experience of many obstetric departments indicate that the size, equipment, services and personnel adequate to maintain a consistently high standard of ordinary obstetrical care and a reasonably economic operation generally require more than 2,000 deliveries." (Standards for Obstetrical and Gynecological Services, Committee on Professional Standards of the American College of Obstetrics and Gynecologists, 1974.) The Committee on Perinatal Health also identified the 2,000 minimum figure for facilities identified as Level II facilities.

In determining the 1,500 target, the Department took into consideration these reports as well as the comments received from the public and from members of the expert advisory panel, particularly the criticism that a 2,000 target was too high. The 1,500 level is in line with the policies of many local and State health planning agencies and can help assure more economic use of specialized resources while avoiding inappropriate utilization of such facilities. The Department also recognizes that there are substantial differences among facilities which provide different ranges of services, and there are circumstances, such as those involving special moral and ethical preferences, which may necessitate the HSA providing an adjustment to this standard.

In addition, in order to promote more economical use of resources the Department has established the 75% minimum occupancy rate in Level II and III facilities. The 75% figure was derived from an analysis of various occupancy rate figures in a number of source documents, whose recommendations range from 50% to over 80%. The Hill-Burton program recommended an occupancy level for obstetrical units of at least 75%. The Department anticipates that institutions operating at Levels II and III will usually be able to exceed this level.

In keeping with the national priority set forth in Section 1502 of the Act for the consolidation and coordination of institutional health services, the consolidation of multiple, small obstetrical units with low occupancy rates should be undertaken unless such action is undesirable because of needs to assure ready access and sensitive care.

**§121.204—Neonatal Special Care Units**

(a) *Standard* (1) Neonatal services should be planned on a regional basis with linkages with obstetrical services.

(2) The total number of neonatal intensive and intermediate care beds should not exceed 4 per 1,000 live births per year in a defined neonatal service area. An adjustment upward may be justified when the rate of high-risk pregnancies is unusually high, based on analyses by the HSA.

(3) A single neonatal special care unit (Level II or III) should contain a minimum of 15 beds. An adjustment downward may be justified for a Level II unit when travel time to an alternate unit is a serious hardship due to geographic remoteness, based on analyses by the HSA.

(b) *Discussion.* For this standard, the Department has adopted the widely endorsed concept of regionalization, involving various levels of care. Under this concept, Level III units are staffed and equipped for the intensive care of new-borns as well as intermediate and recovery care. Level II units provide intermediate and recovery care as well as some specialized services. Level I units provide recovery care.

Neonatal special care is a highly specialized service required by only a very small percentage of infants. The Department believes that four neonatal special care beds for intensive and intermediate care per 1,000 live births will usually be adequate to meet the needs, taking into account the incidence of high risk pregnancies, the percentage of live births requiring intensive care, and the average length of stay. ("Bed" includes incubators or other heated units for specialized care, and bassinets.) In addition, the Department has established a minimum of 15 beds per unit for Levels II and III as the minimum number necessary to support economical operation for these services. Both standards are supported and recommended by the American Academy of Pediatrics.

The American Academy of Pediatrics has noted that "the best care will be given to high risk and seriously ill neonates if intensive care units are developed in a few adequately qualified institutions within a community rather than within many hospitals. Properly conducted, early transfer of these infants to a qualified unit provides better care than do attempts to maintain them in inadequate units." This regionalized approach is reflected in the minimum size standard which is designed to foster the location of specialized units in medical centers which have available special staff, equipment, and consultative services and facilities.

Since perinatal centers which include neonatal units will serve the patient load resulting from a representative population of more than one million, a defined neonatal service area should be identified by the relevant HSAs in conjunction with the State Agency. Special attention should also be given to ensure adequate communication and transportation systems, including joint transfers of mother and child and maintenance of family contact. Hospitals with such units should have agreements with other facilities to serve referred patients. The regional plan should include a structured ongoing system of review, including assessment of changes in health status indicators.



## APPENDIX L

## MEDICAL CENTER OF TARZANA

Historical and Projected Utilization, Total Hospital Patient Days  
Fiscal Years 1977 Through 1987

<u>Fiscal Year Ending</u>	<u>Days</u>	<u>% Occ.</u>
<u>Actual</u>		
1977	35,627	87.9
1978	35,355	87.2
1979	35,353	87.2
1980	34,581	85.3
<u>Projected</u>		
1981	35,600	87
1982	35,600	87
1983	35,600	87
1984	35,600	87
1985	35,600	87
1986	35,600	87
1987	35,600	87

Source: Hospital Records

## APPENDIX M

## Medical Center of Tarzana

SELECTED PROGRAM UTILIZATION  
 ACTUAL AND PROJECTED PATIENT DAYS  
 Fiscal Years 1977 through 1989

Fiscal Year Ending	OB		ICNN		Pediatrics	
	Days	% Occ	Days	% Occ	Days	% Occ
<b>Actual</b>						
1977	7,554	76.6	322	29.4	4,966	64.7
1978	7,860	79.7	82	7.4	5,151	67.2
1979	7,073	71.7	375	34.2	4,665	60.8
1980	7,642	77.5	1,141	104.2	5,304	69.1
<b>Projected</b>						
1981	8,000	81.2	1,000	91.3	6,000	78.3
1982	8,000	81.2	1,040	95.0	6,000	78.3
1983	8,000	81.2	1,040	95.0	6,000	78.3
1984	8,000	81.2	4,380	80.0	6,000	78.3
1985	8,000	81.2	4,653	85.0	6,000	78.3
1986	8,000	81.2	4,930	90.0	6,000	78.3
1987	8,000	81.2	4,930	90.0	6,000	78.3

Note: Projections were made for estimating future revenues and may not reflect service utilization growth trends.

Source: Hospital Records

## APPENDIX N

## Medical Center of Tarzana

ACTUAL AND PROJECTED DELIVERIES  
1978-1985

	Actual		Projected					
	1978	1979	1980	1981	1982	1983	1984	1985
Routine Deliveries	1,563	1,558	1,651	1,733	1,820	1,911	2,006	2,107
C-Section Deliveries (1)	439	538	550	578	607	637	669	702
Total Deliveries	2,002	2,096	2,201	2,311	2,427	2,548	2,675	2,809
Percent Change		4.7%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Perinatal Patient Days(2)	6,884	7,364	7,703	8,089	8,495	8,918	9,363	9,831
Percent Occupancy(3)	69.8%	74.7%	78.2%	82.1%	86.2%	90.5%	95.0%	99.8%

Notes: 1. C-Section projections based on 25% of total deliveries. The C-Section rate may increase as more high-risk patients are served.

2. Patient days are estimates using 3 days per routine birth and 5 days per C-Section.

3. Based on 27 existing licensed perinatal beds.

Source: Hospital Records.

## APPENDIX O

## Medical Center of Tarzana

HIGH RISK DELIVERIES  
1975-1980

<u>Year</u>	<u>Deliveries</u>	<u>Percent High Risk</u>
1975	1987	30.1 %
1976	1950	35.50%
1977	2185	37.2 %
1978	2002	45.3 %
1979	2096	54.5 %
1980 Estimated	2201	58.6 %

## APPENDIX P

Medical Center of Tarzana  
18321 Clark Street, Tarzana, California 91356 | 213 881-0800

May, 1981



Dear Doctor:

The enclosed questionnaire is being circulated among physicians with practices in the San Fernando Valley. As you have privileges at Medical Center of Tarzana, we are especially appreciative of your response to our planning efforts. This survey is not intended to duplicate the questionnaire we sent out last year, but rather to clarify certain findings. Our efforts are aimed primarily at obtaining an expression of the medical staff opinion on the need for or feasibility of expanding the acute care bed capacity of Medical Center of Tarzana.

Friesen International, the planning subsidiary of A.M.I., will be assisting the hospital by collecting and tabulating your responses. Should you have any questions or wish to express any additional feelings regarding our future, please feel free to contact either of us at your convenience.

Sincerely,

*Stephen A. Bowles*

Stephen A. Bowles  
Administrator

*Alfred Dashe, M.D.*

Alfred Dashe, M.D.  
Chief of Staff

/db  
Encl.

HOSPITAL BED NEED SURVEY: SAN FERNANDO VALLEY PHYSICIANS

1. What is your medical specialty?

\_\_\_\_\_ (1)

2. For how long have you been practicing in San Fernando Valley?

\_\_\_\_\_ Less than 3 years    \_\_\_\_\_ 3-5 years    \_\_\_\_\_ Over 5 years (2)  
1    2    3

3. How many hospital admissions do you have on an average per month?

\_\_\_\_\_ patients (3)

4. To what hospital(s) did you admit these patients and what was the distribution?

Hospital		% of patients
_____	(4)	_____ (5)
_____	(6)	_____ (7)
_____	(8)	_____ (9)
_____	(10)	_____ (11)
	Total	100%

5. In the next 5 years or so, do you expect your practice to grow, remain the same or decline?

1 grow \_\_\_\_\_  
2 remain same \_\_\_\_\_  
3 decline \_\_\_\_\_ (12)

6. What is your professional opinion of the overall quality of patient care delivered at each of the following hospitals?

Hospital	Excell.	Good	Fair	Poor	No Opinion	
Medical Center of Tarzana	_____	_____	_____	_____	_____	(13)
West Hills Medical Center	_____	_____	_____	_____	_____	(14)
West Park Hospital	_____	_____	_____	_____	_____	(15)
Parkwood Community Hosp.	_____	_____	_____	_____	_____	(16)
Canoga Park Hospital	_____	_____	_____	_____	_____	(17)
Northridge Hospital	_____	_____	_____	_____	_____	(18)
Valley Presbyterian Hosp.	_____	_____	_____	_____	_____	(19)
Encino Hospital	_____	_____	_____	_____	_____	(20)
Valley Medical Center	_____	_____	_____	_____	_____	(21)
Sherman Oaks Hospital	_____	_____	_____	_____	_____	(22)
	1	2	3	4	5	

7. Please check below those hospitals which indicated unavailability of beds at any time during last year for any of your patients. For the hospitals you check, please also indicate approximately in how many patients' cases did this happen last year? Also indicate whether you are on the active staff of these hospitals.

	Unavailable Beds	In How Many Cases	Check if on Active Staff
Medical Center of Tarzana	_____ (23)	_____ (24)	_____ (25)
West Hills Medical Center	_____ (26)	_____ (27)	_____ (28)
West Park Hospital	_____ (29)	_____ (30)	_____ (31)
Parkwood Community Hospital	_____ (32)	_____ (33)	_____ (34)
Canoga Park Hospital	_____ (35)	_____ (36)	_____ (37)
Northridge Hospital	_____ (38)	_____ (39)	_____ (40)
Valley Presbyterian Hospital	_____ (41)	_____ (42)	_____ (43)
Encino Hospital	_____ (44)	_____ (45)	_____ (46)
Valley Medical Center	_____ (47)	_____ (48)	_____ (49)
Sherman Oaks Hospital	_____ (50)	_____ (51)	_____ (52)
	<u>1</u>		<u>1</u>

8. Do you anticipate admitting more patients to the Medical Center of Tarzana in the next five years or so?

Yes      No      (53)  
1                      2

If yes, how many more per year?      (54)

9. Please check below the number of beds by services that Medical Center of Tarzana should add in the 80's.

	Beds Needed				
	0	up to 50	50-100	100-200	
Medical/Surgical	_____	_____	_____	_____	(55)
Obstetrics	_____	_____	_____	_____	(56)
Pediatrics	_____	_____	_____	_____	(57)
Intensive Care	_____	_____	_____	_____	(58)
Critical Care	_____	_____	_____	_____	(59)
Progressive Care	_____	_____	_____	_____	(60)
Other _____	_____	_____	_____	_____	(61)
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	

10. Additional comments:

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## APPENDIX Q

## PHYSICIAN SURVEY FINDINGS

<b>SAMPLE SIZE</b>	187 Respondents of about 600 MDs surveyed		
<b>PRIMARY AFFILIATION</b>	MCOT:	61%	
	Other Hospitals:	39%	
		<u>100%</u>	
<b>OTHER ADMITTING HOSPITALS NAMED BY PHYSICIANS</b>	Encino Hospital	13	18.6%
	Valley Presbyterian	10	14.4%
	Northridge	10	14.4%
	West Hills	7	10.1%
	Others	29	42.3%
		<u>69</u>	<u>100%</u>
<b>FUTURE PRACTICE PATTERNS</b>	Increase	51%	
	No Change	49%	
	Decline	0%	
		<u>100%</u>	
<b>OPINION OF NEED</b>	Needed and Overdue	90%	
	Not Needed	10%	
		<u>100%</u>	
<b>OPINION OF IMPACT ON OTHER HOSPITALS</b>	Adverse Impact	26%	
	No Adverse Impact	74%	
		<u>100%</u>	
<b>OPINION OF IMPACT ON PRACTICE</b>	Strong	47%	
	Minimal	53%	
		<u>100%</u>	



## APPENDIX R

## Medical Center of Tarzana

MEDICAL STAFF BY CATEGORY  
1980-1981

Speciality	Physicians			Total
	Temporary	Courtesy	Active	
Family Practice	3	20	7	30
Internal Medicine	21	96	52	169
OB / GYN	11	22	23	56
Pediatrics	9	36	30	75
Surgery	18	146	48	212
Anesthesia	3	10	6	19
Dental	4	23	0	27
Emergency Room	0	8	1	9
Pathology	0	0	3	3
Psychiatry	6	22	0	28
Radiology	0	4	5	9
Honorary	-	-	-	6
Totals	75	387	175	643

Source: Hospital Records

BALANCE SHEET ANALYSIS - CURRENT AND FORECAST

LINE NUMBER	ITEM DESCRIPTION	CHFC REFERENCE	CURRENT YR. ( 1981 )	FUTURE YR. 1 ( 1982 )	FUTURE YR. 2 ( 1983 )	FUTURE YR. 3 ( 1984 )	FUTURE YR. 4 ( 1985 )
	DATA						
1	Cash	P5(1)L2	215000	237000	261000	287000	316000
2	Net Accounts Receivable	P5(1)L4 minus 16	7001150	7701000	8471000	9318000	10250000
3	Other Current Assets	Add P5(1)L8 through L14	958000	1056000	1153000	1251000	1348000
4	Total Current Assets	P5(1)L15	8174150	8994000	9885000	10856000	11914000
5	Board Designated Assets	P5(1)L24					
6	Total Prop., Plant, Equip.	P5(1)L31	26371200	26898000	27436000	27985000	28545000
7	less Accum. Depreciation	P5(1)L32	4197740	5087000	5991000	6908000	7848000
8	Net Prop., Plant, Equip.	P5(1)L33	22173450	21811000	21445000	21077000	20697000
9	Construction in Progress	P5(1)L34	144000				
10	Investments & Other Assets	P5(1)L41	50000	60000	70000	80000	90000
11	Intangible Assets	P5(1)L48					
12	TOTAL ASSETS	P5(1)L49	30541600	30865000	31400000	32013000	32701000
13	Total Current Liabilities	P5(2)L12	10052600	9692000	9299000	8729000	9172000
14	Total Deferred Credits	P5(2)L18					
15	Net long-Term Debt	P5(2)L31	14767000	13733000	12772000	11878000	9839000
16	TOTAL LIABILITIES	P5(2)L32	24819600	23425000	22071000	20607000	19011000
17	EQUITY	P5(2)L35 (non-profit) OR P5(2)L47 (investor)	5722000	7440000	9329000	11406000	13690000
	CALCULATIONS						
		FORMULA					
18	Current Ratio	4 ÷ 13	.8131	.9280	1.0630	1.2437	1.2990
19	Acid Test Ratio	1 ÷ 13	.0214	.0245	.0281	.0329	.0345
20	Debt To Equity Ratio	16 ÷ 17	4.3376	3.1485	2.3658	1.8067	1.3887
21	Percent Change in Total Assets	(See instructions)	3.22%	1.06%	1.73%	1.95%	2.15%

APPENDIX S

INCOME STATEMENT ANALYSIS - CURRENT AND FORECAST

LINE NUMBER	ITEM DESCRIPTION	CHFC REFERENCE	CURRENT YR. ( 1981 )	FUTURE YR. 1 ( 1982 )	FUTURE YR. 2 ( 1983 )	FUTURE YR. 3 ( 1984 )	FUTURE YR. 4 ( 1985 )	FUTURE YR. 5 ( 1986 )
DATA								
1	Gross Patient Revenue	P816	39314000	43245000	47569000	52326000	57559000	63315000
2	Total Deductions from Revenue	P8115	7784000	8563000	9419000	10361000	11379000	12536000
3	Net Patient Revenue (1-2)	P8116	31530000	34682000	38150000	41965000	46180000	50779000
4	Total Other Operating Revenue	P8121	196000	215000	237000	261000	287000	315000
5	Total Operating Revenue (3-4)	P8122	31726000	34897000	38387000	42226000	46449000	51094000
6	Total Operating Expenses	P8131	28634000	31497000	34647000	38112000	41923000	46115000
7	Net from Operations (5-6)	P8132	3092000	3400000	3740000	4114000	5707000	6521000
8	Nonoperating Revenue or Expense	P8143	35000	37000	39000	41000	43000	45000
9	Net Income before Taxes & Extraordinary Items (7 + 8)	P8144	3127000	3437000	3779000	4155000	4569000	5024000
10	Provision for Income Taxes	P8146 + 147	1564000	1719000	1890000	2078000	2285000	2512000
11	Extraordinary Items	P8150						
12	Net Income (9 - 10 + 11)	P8152	1563000	1718000	1889000	2077000	2284000	2512000
CALCULATIONS								
13	Operating Margin	FORMULA 7 + 5	9.75%	9.74%	9.74%	9.74%	12.29%	12.76%
14	Return on Equity	(See Instructions)	27.32%	23.09%	20.25%	17.54%	15.52%	13.96%
15	Collection Period	(See Instructions)	65.00	65.00	65.00	65.00	65.00	65.00
16	Annual Percent Change in Oper. Rev. (5)	(See Instructions)	10.06%	9.99%	10.00%	10.00%	10.00%	10.00%
17	Annual Percent Change in Oper. Exp. (6)	(See Instructions)	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%
18	Annual Percent Change in Net Income (12)	(See Instructions)		9.92%	9.95%	9.95%	9.97%	9.98%
STATISTICAL SUMMARY								
19	Patient Days		62100	62140	62140	62140	62140	62140
20	Outpatient Visits		31000	31000	31000	31000	31000	31000
21	Number of Beds/2Occupancy Rate		200/85.1%	200/85.1%	200/85.1%	200/85.1%	200/85.1%	200/85.1%
a. Acute								
b. Psychiatric								
c. Skilled Nursing								
d. Intermediate Care								
22	Reimbursement (Rate Mix %)							
a. Medi-Cal								
b. Medicare								
c. Prepaid Plan								
d. Other								
TOTAL			100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

APPENDIX I

HISTORICAL AND FORECAST PROJECT NET INCOME  
SERVICE (SPECIFY) NICU

LINE NUMBER	PAST YR. 3 ( 1978 )	PAST YR. 2 ( 1979 )	PAST YR. 1 ( 1980 )	CURRENT YR. ( 1981 )	DEVELOPMENTAL YEAR 1 ( 1982 )	DEVELOPMENTAL YEAR 2 ( 1983 )	OPERATIONAL YEAR 1 ( 1984 )	OPERATIONAL YEAR 2 ( 1985 )	OPERATIONAL YEAR 3 ( 1986 )
1	351.79	438.72	449.61	494.57	544.03	598.43	658.27	724.10	796.51
2	82	375	1158	1000	1040	1040	4380	4653	4930
3	28847	164520	520648	494570	565791	622367	2883223	3369237	3926794
4	4910	29778	103088	97925	112027	123229	570878	667109	777505
5	23937	134742	417560	396645	453764	499138	2312345	2702128	3149289
6									
	8392	64137	236077	209608	239792	263771	1221970	1427948	1664252
	57	8037	19934	27318	31252	34377	159258	186103	216900
	1500	9349	395	2519	2882	3170	14686	17162	20002
	40	3976	11085	4247	4859	5345	24762	28936	33724
7	9989	85499	267491	243692	278785	306663	1420676	1660149	1934878
8	16617	16340	16754	16897	16862	16680	292551	281499	269070
9	26606	101839	284245	260589	295647	323343	1713227	1941648	2203948
10	324.46	271.57	245.46	260.59	284.28	310.91	391.15	417.29	447.05
11	(2669)	32903	133315	136056	158117	175795	599118	760480	945341

APPENDIX U

HISTORICAL AND FORECAST PROJECT NET INCOME  
SERVICE (SPECIFY) Respiratory Therapy

LINE NUMBER	PAST YR. 3 ( 1978 )	PAST YR. 2 ( 1979 )	PAST YR. 1 ( 1980 )	CURRENT YR. ( 1981 )	DEVELOPMENTAL YEAR 1 ( 1982 )	DEVELOPMENTAL YEAR 2 ( 1983 )	OPERATIONAL YEAR 1 ( 1984 )	OPERATIONAL YEAR 2 ( 1985 )	OPERATIONAL YEAR 3 ( 1986 )	
1	Charge per Unit of Service	6.95	6.30	8.87	9.71	10.68	11.75	12.93	14.22	15.64
2	Total Number of Clifc Units	166332	181077	203352	179235	200000	200000	337000	348000	360000
3	Gross Operating Revenue (1 x 2)	1156682	1140859	1781799	1739969	2136000	2350000	4357410	4948560	5630400
4	Deductions from Gross Revenue	261134	253763	352796	344514	422928	465300	862767	979815	1114819
5	Net Operating Revenue	895548	887096	1429003	1395455	1713072	1884700	3494643	3968745	4515581
6	Operating Expenses by Natural Class									
	Scaffing	294355	381932	474521	557489	684284	752712	1395152	1584760	1803348
	Supplies	57369	56203	87918	107025	131367	144504	267838	304239	346203
	Fees	125998	118625	101178	113400	131385	144549	268024	304366	346326
	Purchased Services	3676	3601	933	11556	14184	15602	28918	32848	37379
	Other	43091	42216	78820	67596	82970	91267	169163	192153	218657
7	Total Direct Project Expenses	524489	602577	743370	857066	1044190	1148634	2129095	2418386	2751913
8	Total Indirect Project Expenses	12962	12745	13069	21486	21639	21666	128138	124868	121186
9	Total Project Expenses (7 + 8)	537451	615322	756439	878552	1065829	1170300	2257233	2543254	2873099
10	Expenses/Unit (9 ÷ 2)	3.23	3.40	3.72	4.90	5.33	5.85	6.70	7.31	7.98
11	Net Operating Income (5 - 9)	358097	271774	672564	516903	647243	714400	1237410	1425491	1642482

HISTORICAL AND FORECAST PROJECT NET INCOME  
SERVICE (SPECIFY) Clinical Laboratory

LINE NUMBER	PAST YR. 3 ( 1978 )	PAST YR. 2 ( 1979 )	PAST YR. 1 ( 1980 )	CURRENT YR. ( 1981 )	DEVELOPMENTAL YEAR 1 ( 1982 )	DEVELOPMENTAL YEAR 2 ( 1983 )	OPERATIONAL YEAR 1 ( 1984 )	OPERATIONAL YEAR 2 ( 1985 )	OPERATIONAL YEAR 3 ( 1986 )	
1	Charge per Unit of Service	1.62	1.89	1.94	2.13	2.34	2.57	2.83	3.11	3.42
2	Total Number of CHFC Units	2233477	2170746	2384045	2349784	2350000	2350000	2631000	2654000	2678000
3	Gross Operating Revenue (1 x 2)	3623577	4104760	4634374	5005040	5499000	6039500	7445730	8253940	9158760
4	Deductions from Gross Revenue	659651	685687	917606	990998	1088802	1195821	1474255	1634280	1813434
5	Net Operating Revenue	2963926	3419073	3716768	4014042	4410198	4843679	5971475	6619660	7345326
6	Operating Expenses by Natural Class:									
	Staffing	761678	864591	951158	1040318	1144455	1258901	1550377	1720323	1909468
	Supplies	277516	319382	326835	343895	378319	416151	512503	568682	631207
	Fees	514930	554393	584642	631403	693718	761903	939304	1041263	1155409
	Purchased Services	140516	156179	133822	163152	179484	197432	243144	269797	299460
	Other			3059	4800	5280	5808	7153	7937	8810
7	Total Direct Project Expenses	1694640	1894585	1999516	2183568	2401256	2640195	3252481	3608002	4004354
8	Total Indirect Project Expenses	74609	73370	75226	87382	87537	86955	148466	147093	141896
9	Total Project Expenses (7 + 8)	1769249	1967955	2074742	2270950	2488793	2727150	3400947	3755095	4146250
10	Expenses/Unit (9 ÷ 2)	.79	.91	.87	.97	1.06	1.16	1.29	1.41	1.55
11	Net Operating Income (5 - 9)	1194677	1451118	1642026	1743092	1921405	2116529	2570528	2864565	3199076

## APPENDIX V

## MEDICAL CENTER OF TARZANA EXPANSION ALTERNATIVES

Summary of Cost Estimates for  
Alternate SchemesAlternate I (255 Beds)

Site Work inc. Utility Services	\$ 550,000
Remodel Existing Bldg.	2,291,350
New Construction	<u>6,576,960</u>
Total	\$ 9,418,310

Alternate #II (266 Beds)

Site Work inc. Utility Services	\$ 550,000
Remodel Existing Bldg.	4,251,057
New Construction	<u>11,809,686</u>
Total	\$16,610,743

Alternate #III (346 Beds)

Site Work inc. Utility Services	\$ 550,000
Remodel Existing Bldg.	6,690,371
New Construction	<u>19,187,491</u>
Total	\$26,427,862

Alternate #IV (317 Beds)

Site Work inc. Utility Services	\$ 550,000
Remodel Existing Bldg.	3,327,490
New Construction	<u>11,871,940</u>
Total	\$15,749,430

Alternate #V (212 Beds)

Site Work	\$ 149,837
Remodel Existing Bldg.	210,000
New Construction	<u>2,356,200</u>
Total	\$2,716,037

## APPENDIX W

## MEDICAL CENTER OF TARZANA

## PRO FORMA PROFITABILITY

## ALTERNATIVE I

Operating Revenue		
Inpatient		6346620
Ancillary		<u>5505003</u>
Total Operating Revenue		11,851623
Less: Deductions from Revenue		
Uncollectable & Ads		237032
Net Patient Revenue		11,614591
Less: Operating Expenses		
Salaries & Wages	4148068	
Prof Fees	583530	
Supplies	1422195	
Purchased Services	651839	
Depreciation	462500	
Interest	2275500	
Other	<u>497768</u>	
Total Operating Expenses		<u>10041400</u>
Net Income Before Management Fee, Cont. & Taxes		1573191
Management Fee 4%		<u>474065</u>
Net Income Before Cont. & Taxes		1099126
Cont. @ 55%		<u>904365</u>
		194761
Taxes @ 50.86%		<u>99055</u>
Net Profit		<u><u>95706</u></u>



## ASSUMPTIONS - ALTERNATIVE I

## Assuming 55 Beds

12	Neo Natal	ICU	Current Rate	450.00
7	Ped	ICU		
36	M/S			180.00

1983 Rates will be up 40%  
Occupancy @ 80%

16 Beds @ \$630.00 per day X 5840 Pt. Days  
29 Beds @ 252.00 per day X 10585 Pt. Days

Ancillary Revenue @ 133% of Routine 4,139,100 = 5505,003

ICU =	3,679,200
M/S =	2,667,420

Bad Debts & Other Adjustments Approx. 2% of Charges

## Other Operating Expenses

Salaries & Wages including Registry & Fringe	35%
Prof. Fees @ 10.60% of Ancillary	
Supplies	12%
Purchased Services	5.5%

Depreciation on 18.5 Mill 40 Years =	462,500
Int. @ 14% 30 years = 1.025% per mo. of 18.5	Mill
Other	4.2%

Manag. Fee @ 4%

Cont. @ 55% of Exp. & 35% Allowable Manag.  
Fee = 55% of 1,644,301

Taxes @ 50.86%

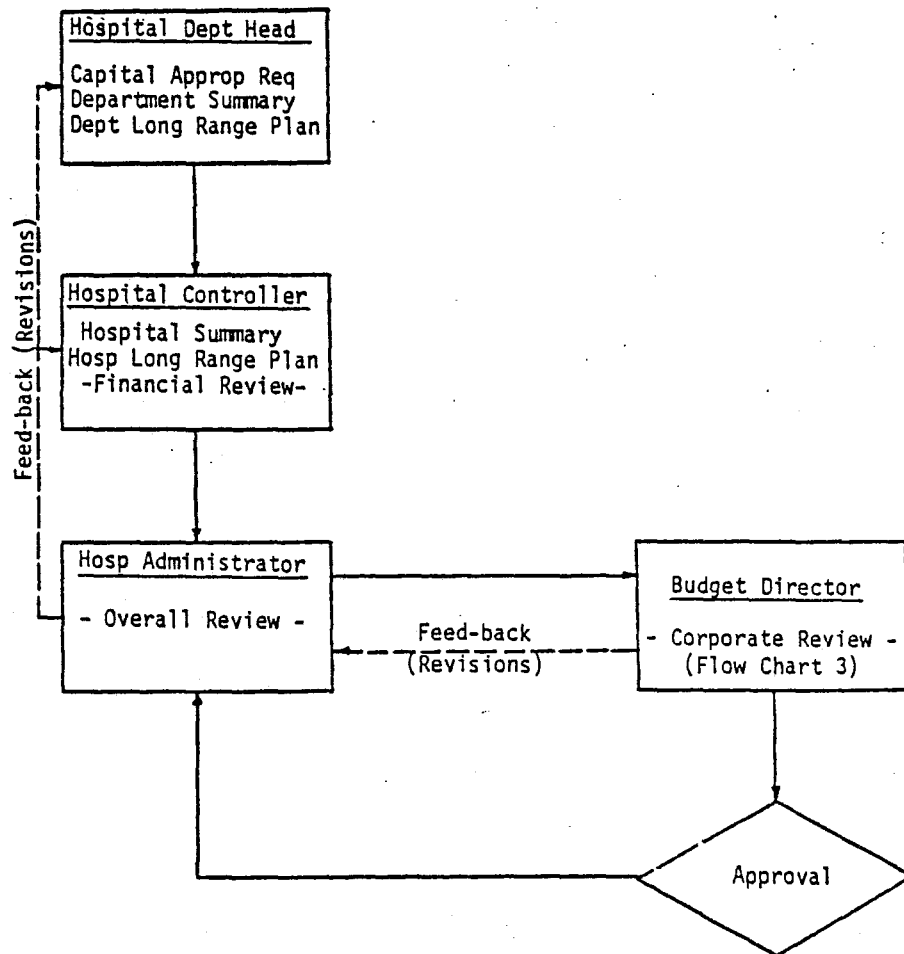
APPENDIX X

MEDICAL CENTER OF TARZANA DECISION MAKING PROCESS

Capital Budget System

Flow Chart 1

Flow Chart  
Initial Preparation  
Review & Approval

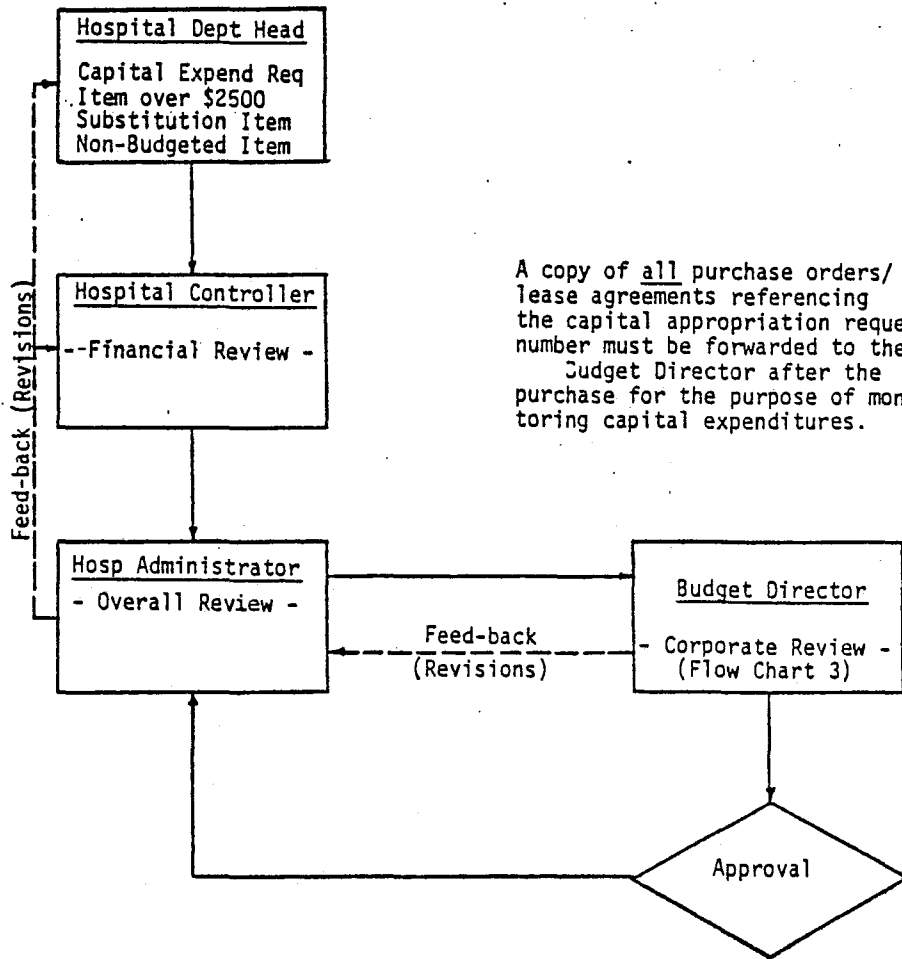


Source: Medical Center of Tarzana

Capital Budget System

Flow Chart 2

Flow Chart  
Monitor & Control  
(Capital Expenditure Request)

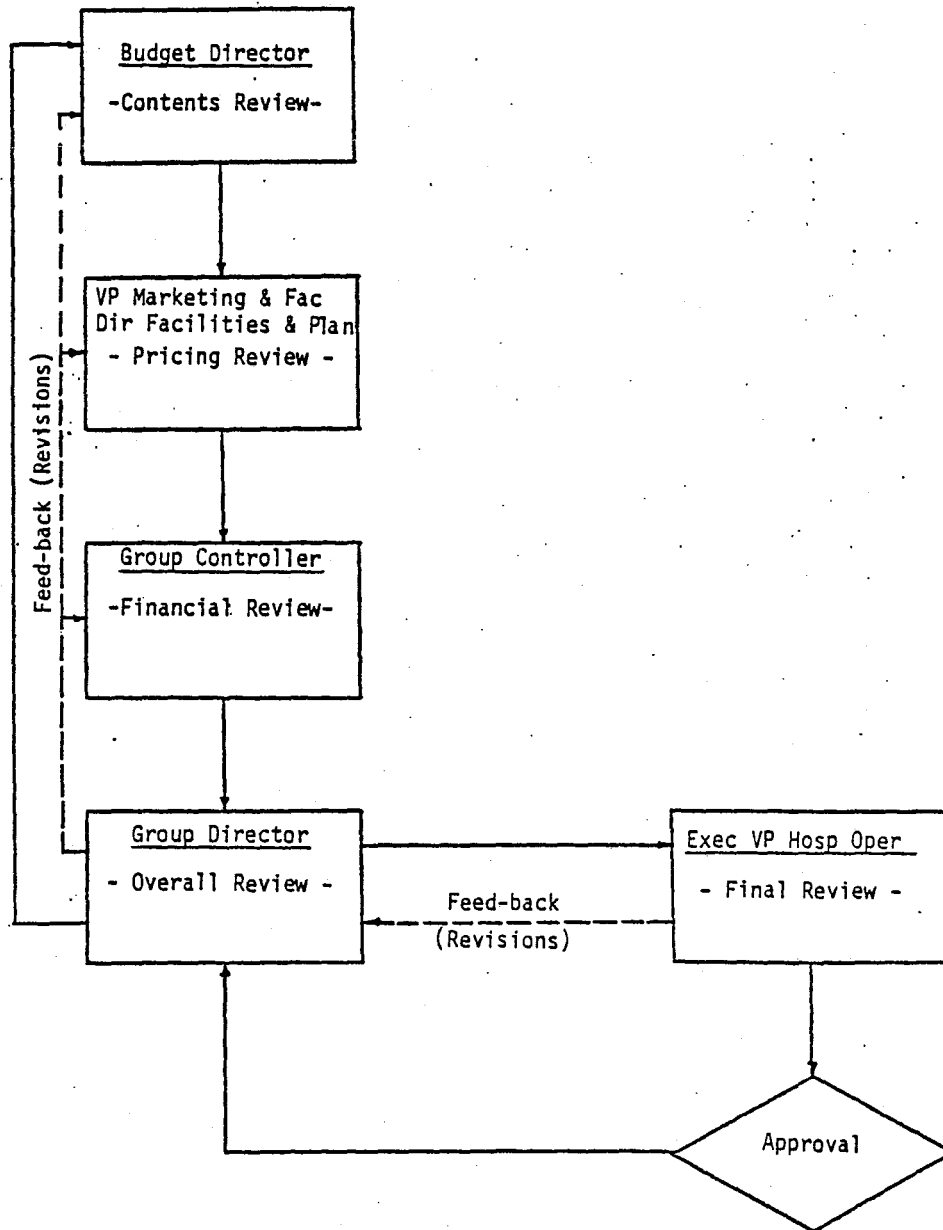


Source: Medical Center of Tarzana

Capital Budget System

Flow Chart 3

Flow Chart  
Corporate Review



Source: Medical Center of Tarzana

## APPENDIX Y

Medical Center of Tarzana  
18321 Clark Street, Tarzana, California 91356 | 213 881-0800

### MEDICAL CENTER OF TARZANA



#### HISTORY

Medical Center of Tarzana was developed by a partnership between Hyatt Medical Enterprises and 103 local physician investors desiring a Valley "Medical Center" capable of offering a wide range of services. As a result of this physician demand and involvement, Medical Center of Tarzana opened in October, 1973 as a 200 bed acute care facility offering Pediatrics, Obstetrics and critical care beds as well as medical-surgical services. Medical Center of Tarzana was the first hospital in the San Fernando Valley to have a CT Scanner; provide modern perinatal services including fetal monitoring; offer intensive care newborn nursery services and offer organized out-patient surgery services. With strong physician support and community acceptance, Medical Center of Tarzana experienced high utilization very quickly and was operating at capacity in late 1975.

Hyatt Medical Enterprises owned and managed the hospital until August, 1980, at which time the corporation was acquired by American Medical International..

#### SERVICE AREAS

The Medical Center of Tarzana service area extends to the Central and Western portions of the San Fernando Valley. Based on 1979 patient origin data, Medical Center of Tarzana's service area is displayed in Exhibit I. The yellow and pink areas combined contribute 72% of all patient admissions and are designated as Medical Center of Tarzana's service area. The communities of Encino, Tarzana, Reseda and the West Van Nuys (pink shaded area) contribute the greatest percentage of admissions (20%) and are the hospital's primary service areas. Other areas generating a significant number of admissions are the Thousand Oaks and Simi Valley areas of Ventura County. In Los Angeles County, the Westlake community to the West and the Saugus/Newhall area to the North account for slightly more than 3% of admissions. An area currently undeveloped and offering the potential for large housing developments over the next 5 years is the Santa Monica Mountain area to the South extending to the Pacific Ocean. The future of this area depends heavily on the extension of Reseda Boulevard to the coast.

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POPULATION

Our service area functions as a major white-collar business center and upper-income suburb of Los Angeles. This area supports one of the highest standards of living in the Los Angeles basin. The average family income is \$31,000 and more than 60% are employed in white collar positions. Approximately 92% of the population is Caucasian and 7% is Hispanic. The population in our service area is projected to increase by 70,000 over the next 10 years. This represents an annual growth rate of 1.1% which is twice the rate for Los Angeles County as a whole.

COMPETITION

Sixteen hospitals surround Medical Center of Tarzana, two of them are A.M.I. facilities - Riverside Hospital and Medical Center of Encino. Medical Center of Encino is currently closed for renovation and due to open early in 1982. Since M.C.T.'s opening in 1973, five of these competing hospitals have increased their number of licensed beds.

	<u>1973</u>	<u>1980</u>
West Hills Hospital	116	236
Northridge Hospital	219	319
Valley Hospital	66	178
Valley Presbyterian Hospital	289	363
Encino Hospital	164	189

Additionally, the 3 major competitors, Northridge, Valley Presbyterian and Encino all currently have filed Notices of Intent with the State for additional services or beds. Occupancy at these facilities ranges from a low of 58% at Encino to a high of 71% at Northridge compared to M.C.T.'s occupancy of 84% for the same period of time.

PLANS FOR THE FUTURE

Medical Center of Tarzana provides the highest quality health care to all patients, regardless of their station in life. In pursuing this purpose, Medical Center of Tarzana has emerged as a leader in its community. The organization is committed to achieving improvements in the community health care delivery system.

Medical Center of Tarzana has attempted to deal with the many issues influencing the health care delivery system:

- \* A mal-distribution of facilities and services

-3-

- \* An increasing scarcity of health manpower resources
- \* The ever increasing cost of goods & services
- \* A changing population with expanded health expectations

These issues are incorporated in the hospital's planning efforts. The Medical Center of Tarzana Strategic Plan has been developed over the course of the last year. A portion of that plan is documented in the Master Facility Plan for 1970-1990, Exhibit 2.

## EXHIBIT 2

SUMMARY OF MEDICAL CENTER OF TARZANA  
MASTER FACILITY PLAN 1970-1990

Medical Center of Tarzana's Master Facility Plan is divided into 3 phases. It addresses the building and physical plant requirements necessary to enable the hospital to continue its purpose. Phase I looks at the facility as originally constructed. Phase II addresses the current building needs. to approximately 1982. Phase III is long range planning, 1982 to 1990, and provides for major renovation and expansion.

PHASE I

The existing building, a 200-bed hospital and ancillary services, represent Phase I of the M.C.T. plan, now complete. This consists of a six-story patient tower, a two-story ancillary area and a two story lobby and outpatient surgical center area. Phase I also includes a seven-story medical office building and two acres of parking.

PHASE II

Phase II of the Master Facility Plan calls for the construction of twin, two-story additions (12,500 square feet) to house an expanded 15-bed neonatal intensive care unit and related services including the hospital laboratory, respiratory therapy and social services and the expansion of educational facilities. A Certificate of Need for this project was filed with the Office of Statewide Health Planning and Development in August, 1980, with the final approval expected in Spring of this year.



EXHIBIT II CON'T.

Phase II will enable M.C.T. to further develop and expand its role as a Regional Perinatal Center.

PHASE III

Phase II provides for major renovation and expansion of the hospital to 357 beds. Construction involves a five-story "Womens & Childrens" patient tower housing expanded perinatal, gynecology, pediatric and neonatal services. The existing 6 story patient tower will be remodeled to accomodate adult medical/surgical and critical care beds. The existing ancillary area will be expanded for larger laboratory and radiology services and remodeled to provide for centralization of in-patient and out-patient surgery. While the implementation time for Phase III has not yet begun, it is hoped that construction would begin prior to 1985. Such efforts will help secure M.C.T.'s position as a major tertiary medical center in the metropolitan San Fernando Valley area to the year 2000.

LONG RANGE MASTER PLAN  
1970-1990  
LICENSED BED CAPACITY SUMMARY

BED CLASSIFICATION	PHASE I	PHASE II	PHASE III
MEDICAL/SURGICAL	137	137	262
(DOU INCLUDED IN M/S)	(23)	(23)	(37)
(COU INCLUDED IN M/S)	(3)	(3)	(3)
PERINATAL	27	27	27
(BASSINETS)	(27)	(27)	(27)
PEDIATRICS	21	21	21
INTENSIVE CARE - ADULT	7	7	15
INTENSIVE CARE - PEDIATRICS	0	0	7
CORONARY CARE	5	5	10
INTENSIVE CARE NEWBORN NURSERY	3	15	15
TOTAL	200	212	357

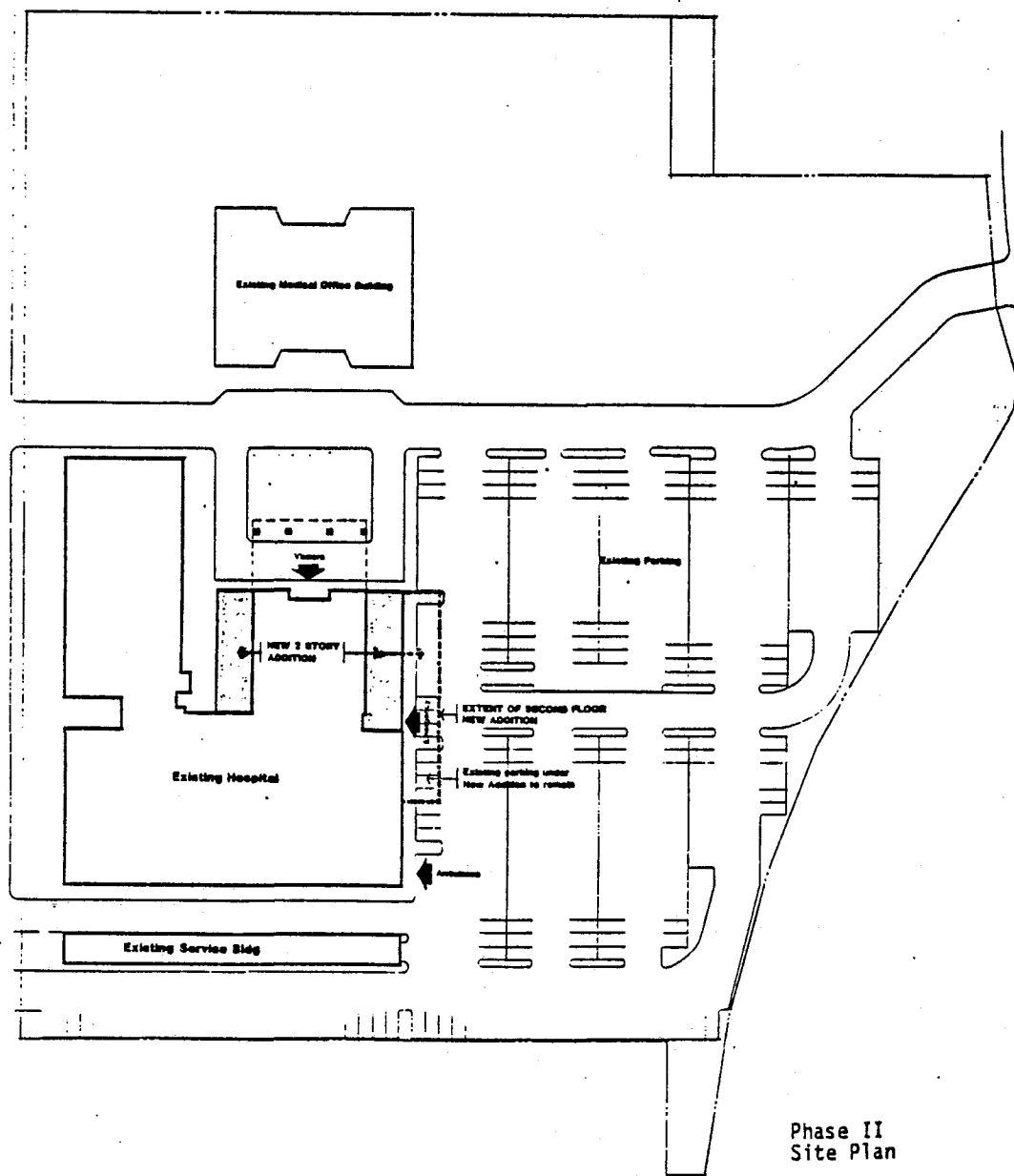
## MEDICAL CENTER OF TARZANA

## LONG RANGE MASTER PLAN

1970-1990

## BED/SERVICE LOCATION SUMMARY

	PHASE I	PHASE II	PHASE III
<b>PATIENT TOWER</b>			
1st Floor	23 DOU 5 CCU 3 COU	23 DOU 5 CCU 3 COU	15 ICU-ADULT 10 CCU 3 COU
2nd Floor	37 M/S	37 M/S	37 DOU
3rd Floor	37 M/S	37 M/S	37 M/S
4th Floor	37 M/S	37 M/S	37 M/S
5th Floor	27 Perinatal 27 Bassinets 3 NICU	27 Perinatal 27 Bassinets -	37 M/S - -
6th Floor	21 Pediatrics	21 Pediatrics	37 M/S
<b>ANCILLARY BUILDING</b>			
2nd Floor	7-ICU-ADULT	7-ICU-ADULT	-
<b>OUTPATIENT SURGICAL CENTER BUILDING</b>	-	15 NICU	15 NICU
<b>PERINATAL/WOMEN'S CHILDREN'S TOWER</b>			
1st Floor	-	-	LAB & EDUCATION
2nd Floor	-	-	27 PERINATAL 27 BASSINET
3rd Floor	-	-	37 M/S (GYN)
4th Floor	-	-	37 M/S (GYN)
5th Floor	-	-	21 PEDIATRICS 7 ICU-PEDIATRICS



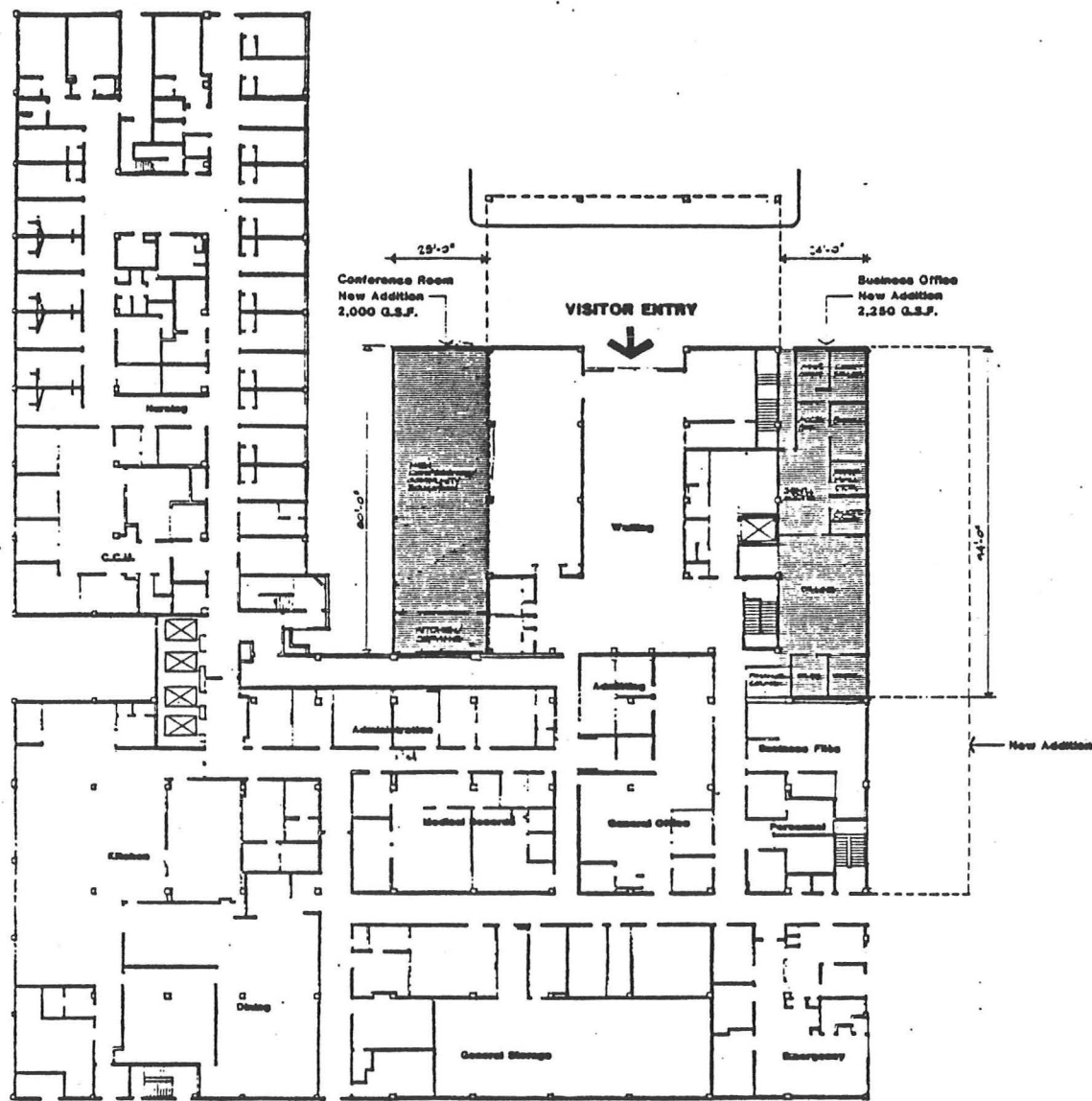
Phase II  
Site Plan

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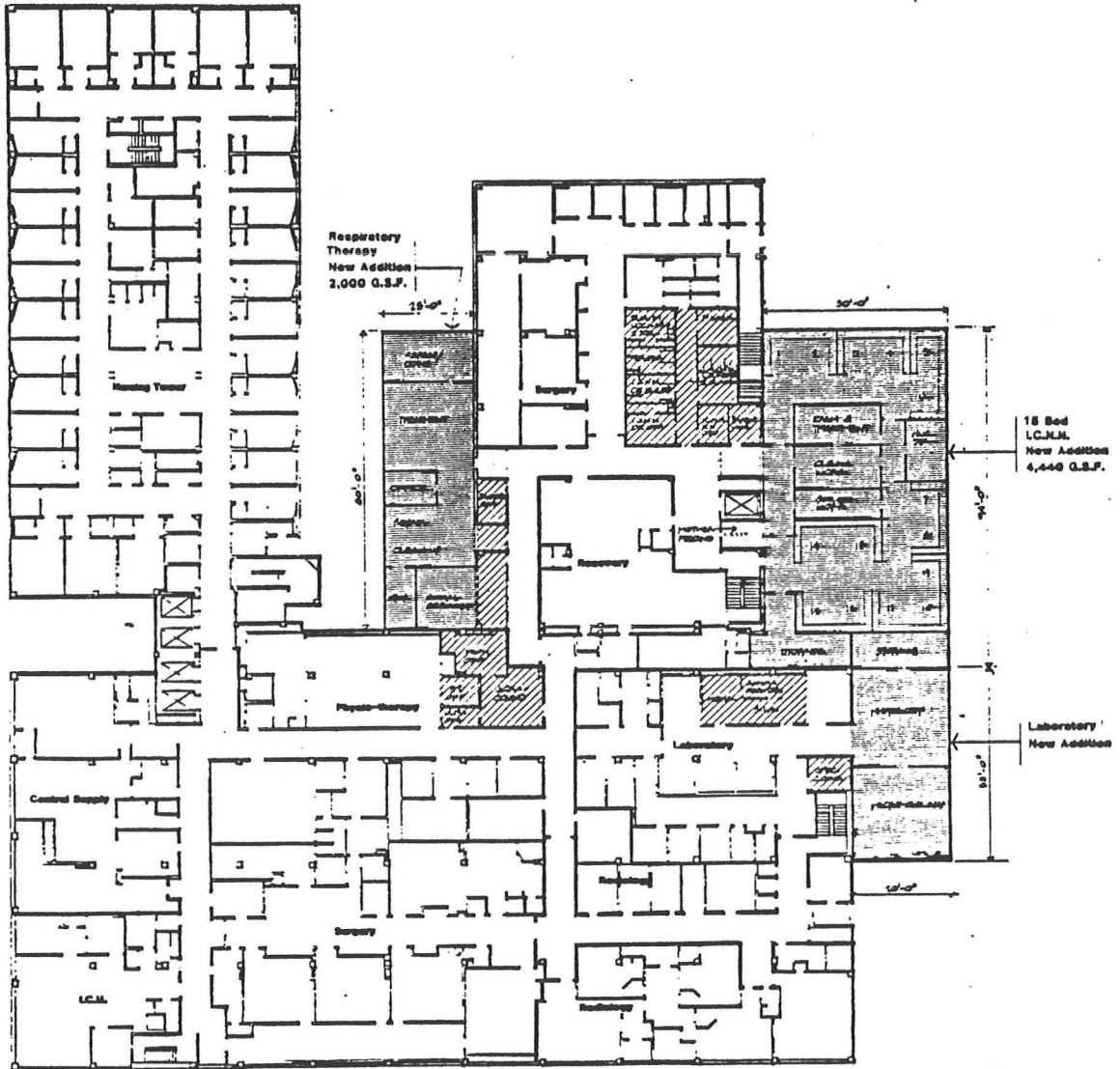
# MEDICAL CENTER OF TARZANA

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Phase II  
Ground Floor Plan



**MEDICAL CENTER OF TARZANA**



Phase II  
Second Floor Plan

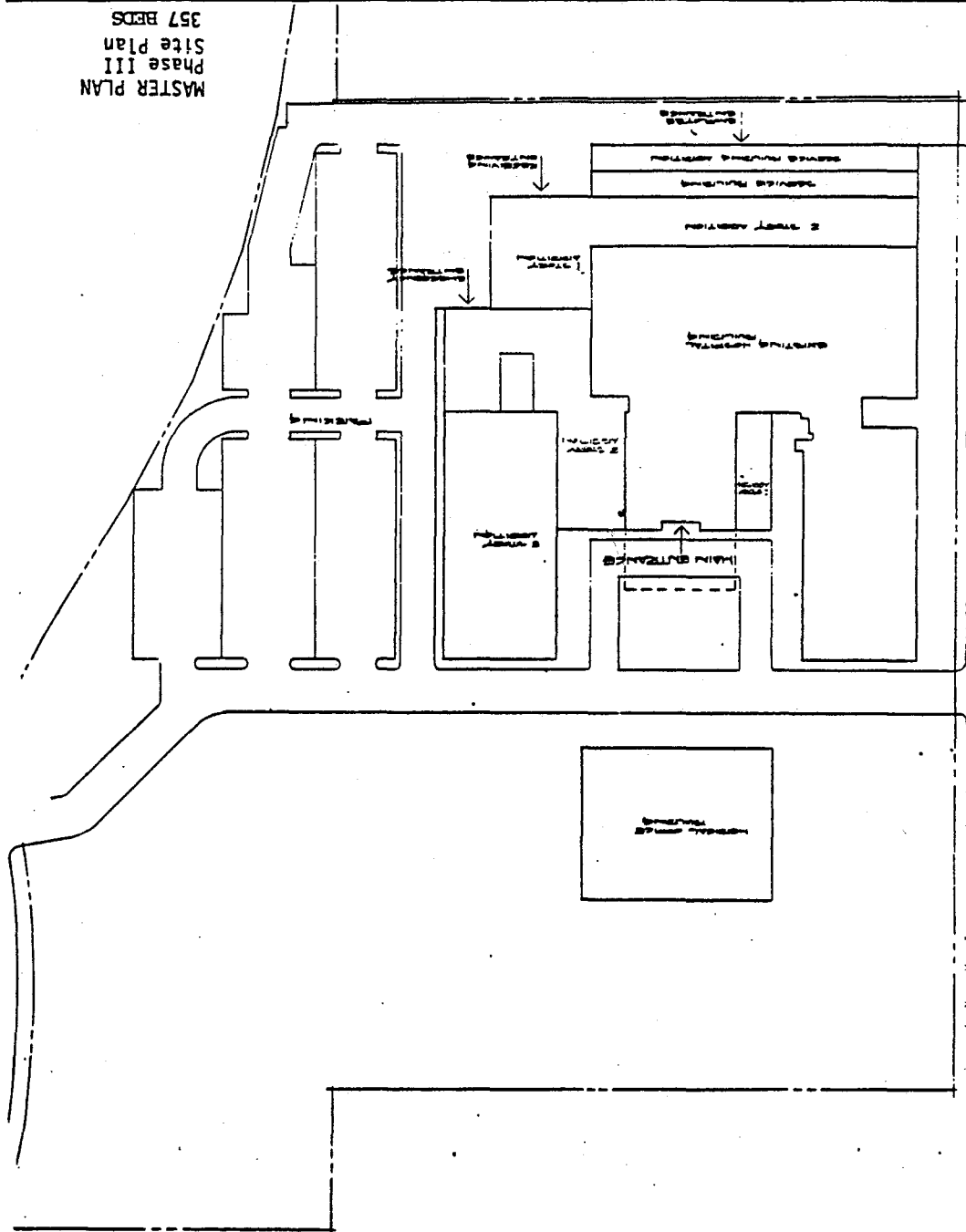
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# MEDICAL CENTER OF TARZANA

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# MEDICAL CENTER OF TARZANA

MASTER PLAN  
Phase III  
Site Plan  
357 BEDS



MEDICAL CENTER OF TARZANA  
STATEMENT OF OPERATIONS

	1981	% OF GROSS	1980	% OF GROSS	1979	% OF GROSS	1978	% OF GROSS
GROSS REVENUE	42,346,000	100.0%	35,952,000	100.0%	30,661,000	100.0%	27,954,000	100.0%
DEDUCTIONS FROM REVENUE								
UNCOLLECTABLES & ADJUSTMENTS	759,000	1.8%	596,000	1.7%	813,000	2.7%	753,000	2.7%
CONTRACTUAL ADJUSTMENTS	7,012,000	16.6%	6,281,000	17.4%	4,183,000	13.6%	3,695,000	13.2%
TOTAL DEDUCTIONS FROM REVENUE	7,771,000	18.4%	6,877,000	19.1%	4,996,000	16.3%	4,448,000	15.9%
NET REVENUE	34,575,000	81.1%	29,075,000	80.9%	25,665,000	83.7%	23,506,000	84.1%
EXPENSES								
SALARIES, WAGES & BENEFITS	14,702,000	34.7%	12,322,000	34.3%	10,232,000	33.4%	8,977,000	32.1%
OTHER OPERATING EXPENSES	15,862,000	37.5%	13,689,000	38.1%	13,702,000	44.7%	13,302,000	47.6%
TOTAL OPERATING EXPENSE	30,564,000	72.2%	26,011,000	72.3%	23,934,000	78.1%	22,279,000	79.7%
INCOME BEFORE TAXES	4,011,000	9.5%	3,064,000	8.5%	1,731,000	5.6%	1,227,000	4.4%
INCOME TAXES	2,042,000	4.8%	1,545,000	4.3%	8,580,000	2.8%	632,000	2.3%
NET INCOME	1,969,000	4.6%	1,519,000	4.2%	873,000	2.8%	595,000	2.1%
PATIENT DAYS		61,427		60,583		59,433		60,685
AVERAGE DAILY CENSUS		168		166		163		166



## APPENDIX Z



The Administration of the Medical Center of Tarzana, along with the hospital's Board of Directors and, Hyatt Medical Enterprises are committed to long-range planning efforts in order to better serve the medical and patient communities of the San Fernando Valley. As a result of planning efforts the Board has resolved to pursue expansion efforts at Medical Center of Tarzana. The minutes of the Board of Director's meeting reflect this commitment.

"The regular meeting of the Board of Directors of the Medical Center of Tarzana, a California corporation, was held on July 18, 1979, at 16633 Ventura Boulevard, Encino, California, at 12:30 p.m."

Mr. Bowles reported on the results of substantial hospital long-range planning. In the past, this Board and the Executive Committee of the Medical Staff have discussed possible expansion in depth. Long-range planning indicates that such expansion is necessary. Clearly, however, the hospital requires expansion in its ancillary service capability, as well as its Neo-Natal bed capacity. After discussion, upon resolution duly made and seconded, and unanimously carried, it was:

RESOLVED, that the Board of Directors deems long-range planning to be a continuing responsibility of the hospital, and that hospital administration is authorized and directed to pursue the results thereof, including but not limited to expansion of the hospital's ancillary service capability, its Neo-Natal ICU bed capacity, and to the extent feasible, its medical-surgical bed capacity.

RESOLVED, FURTHER, that hospital administration is authorized to explore with Hyatt Medical Enterprises, Inc. the possibility of combining long-range planning with planning for Medical Center of Encino, in order to better serve the combined medical committees and patients seeking hospital care in the San Fernando Valley.