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EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITAL

Mary R. Pippin

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Date

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EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS
BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITAL

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science
at Virginia Commonwealth University

By

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ABSTRACT

EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITALS

Mary R. Pippin, R.N., B.S.N.

Medical College of Virginia-Virginia Commonwealth University, 1987

Major Director: Dr. Barbara Mark

The purpose of this study was to determine the extent to which executive nurses participate in strategic planning for their institutions, and the extent to which these executive nurses utilize the strategic planning process for their nursing departments. The effects of ownership, size, and educational level of the executive nurse on the extent of participation in institutional strategic planning and the utilization of the strategic planning process for their nursing departments was also examined.

The population of the study included all executive nurses employed in short-term, nonmilitary, Virginia hospitals, which were members of the Virginia Hospital Association. Questionnaires were mailed to 114 executive nurses, 60 returned the survey with a response rate of 53 percent. The 60 hospitals included: 14 small institutions (< 99 beds), constituting 24 percent of the sample; 30 medium-sized institutions (100-399 beds), comprising 58 percent of the sample;
and 11 large institutions (> 400 beds), constituting 18 percent of the sample. There were 48 not-for-profit institutions constituting 80 percent of the sample, and 12 for-profit (investor owned) comprising 20 percent of the sample.

The typical nurse executive in this study held a master's degree, had 21-25 total years of nursing experience of which one to five years was at the executive level, and had been in his/her present position one to five years. Slightly over half of nursing departments had long-range plans covering three years or less. The majority of long-range plans for the department of nursing were formulated by the strategic planning process. Participation in hospital strategic planning was influenced by the institution's size and the nurse executive's educational level. Utilization of the strategic planning process for the department of nursing was influenced by neither size nor ownership, only the executive nurse's educational level.
CHAPTER ONE

Introduction

Health care costs continue to accelerate in the United States. In 1966, when Medicare and Medicaid were implemented, total spending by individuals, insurance companies, and the government was six percent of our gross national product (GNP). By 1985, national health expenditures represented 10.6 percent of the GNP. This continued increase in the cost of health care, combined with a societal belief that all people have a right to health care, resulted in various consumer groups directing pressure on hospitals to become more cost effective.

The external demands for cost effectiveness along with increased federal and state regulations forced hospitals to begin responding to their external environment in a manner similar to other service organizations. Hospitals, like other organizations, must effectively manage the demands of their external environment in order to survive (Pfeffer and Salancik, 1978). External events that are currently having an impact on hospitals (Coddington, Palmquist and Tollinger, 1985) include prospective payment instead of cost reimbursement, decreased occupancy rates, competition, changing relationships between hospital administration and physicians,
deregulation of hospital building, continued improvement in technology and equipment, difficulty in raising capital, and financial problems secondary to treating the indigent.

In order to prosper in today's turbulent environment, organizations must engage in methods that enable them to match their organizational strengths with opportunities in their external environments. Planning is one method that organizations have used to accomplish this.

Because the planning process has evolved continually since its inception, business planning has taken many forms. Over the years, various planning approaches to managerial problems were formulated: financial ratio analysis, management by objectives, capital budgeting, profit planning, long-range planning, strategic planning, issue analysis, and strategic portfolio analysis (Ansoff, Declerck and Hughes, 1976:41).

Planning by hospitals began with the implementation of the Hill-Burton Act of 1946, which allotted money initially for the building of hospitals, and then later, for renovation, special services, and nursing homes. Later, project planning was done in order to obtain money through the Comprehensive Health Planning Act of 1965, for development and monitoring of additional health care resources, such as the construction of new hospitals, specialty services, and nursing homes, through the creation of state and sub-state health planning agencies. Project planning evolved into
long-range planning by expanding the time frame from that necessary to complete just one proposed project to three-year planning in order to meet Medicare regulatory requirements.

Long-range planning in hospitals frequently was done by external consultants, was very expensive, and was very time consuming. The focus of the process was frequently on the generation of a plan to meet regulatory requirements. There was little flexibility once the plan was accepted and implementation begun. Long-range plans usually covered three to five years, and review of the plan once formulated generally occurred just prior to the generation of the next plan. Long-range planning tended to become a paper exercise for regulatory documentation rather than a process for both charting the hospital's future course and acting as an instrument to measure the progress of the hospital in meeting milestones toward future goals.

Traditionally, hospitals have adopted industry's planning processes because industries were confronted earlier than hospitals by external environment demands; therefore, industry had experience in formulating effective methods to manage the external environment. In order to be able to respond more rapidly to environmental changes, hospitals adopted from industry the strategic planning process.

Strategic planning is a method currently utilized to manage the boundary between the hospital and its external
environment. Strategic planning is the process by which hospitals assess the health care market and their true competitive position within the market. According to Bourgeois, "one can find among the many definitions that strategy has the two primary purposes of defining the segment of the environment in which the organization will operate and providing guidance for subsequent goal-directed activity within that niche" (1980:27). This process determines the hospital's future direction while concurrently addressing community needs and satisfying regulatory requirements (Domanico, 1981).

Like hospital planning, nursing service departmental planning has been an ongoing evolutionary process. Although planning is recognized as a fundamental part of good management, because of the heavy demands for immediate resolution of daily crises and a lack of knowledge and experience in establishing and utilizing a formal planning program (Fox and Fox, 1983), planning by nurse executives traditionally has been relegated to the last priority.

Several additional factors have also contributed to the late entry by nurse executives into the field of formalized planning. A cursory examination of hospital administration practices (Gugenheim, 1979) revealed a failure to solicit nursing input into significant policy-making decisions, program planning and design, and financial management. Specific
barriers identified for failure to solicit nursing input were: (a) failure of hospital administration, physicians, and some nurses to recognize and acknowledge a nurse's capability to fulfill a top management role, (b) reluctance on the part of nurse executives to accept and implement their roles in top management, and (c) longstanding difficulties in interprofessional collaboration (Gugenheim, 1979).

The first barrier to formalized planning by nursing prior to the 1980's was frequently the nurse executive's lack of educational preparation in administration. In 1977, 49.5 percent of nurse executives cited diplomas and 22.5 percent cited the associate degree as their highest degree (Aydelotte, 1984). These nurses graduated in an era when nurses were generally taught by physicians and nurses did not feel part of administration (Niederbaumer, 1979).

The accuracy of this perception was depicted in the late 1950's when a study of nursing leadership at various levels in 15 hospitals discovered that nurses did not perceive the executive nurse to be a leader in formulating ideas, long-range planning, or promoting nursing as a profession (Hagen and Wolf, 1961). Instead, the role of the executive nurse was seen primarily as directed toward acquiring nursing personnel, coordinating departments, enforcing hospital policies, providing for inservice training, and generally improving nursing services (Weisman, Alexander and Morlock, 1981).
Twenty years later, the trend continued at the administrator level when in 1977, a survey conducted by the Professional Services Committee of the Pennsylvania Hospital Association reviewed 145 sets of responses from Chief Operating Officers (COO) and Directors of Nursing Service (DNS) concerning the perceived role of the DNS (Hospital Topics, 1979). The study revealed: (a) half of COOs failed to view the DNS's formal position and title at the first level of management below the COO or viewed the DNS at one or even two levels below the first line, (b) the DNS was perceived by the COOs to have increasingly less authority as the subrole in which the DNS was functioning moved away from that of clinician to fiscal officer and then administration, i.e., the DNS was viewed as a nurse not an administrator, and (c) the DNS believed that the positions of DNS and director of medical service were equal, but they actually were not.

Additionally, in most institutions contributing to policy formation required being a member of the administrative executive staff, the hospital governing body, and the hospital long-range planning committee (Niederbaumer, 1979). Niederbaumer stated that in many institutions the DNS was unknown to the trustees and others in policy-making positions and she did not participate in hospital decisions. Therefore, the DNS was denied membership into groups responsible for organizational-environmental boundary management.
More recently, nurse executives are being included in hospital administration groups responsible for boundary management. In 1982, the American Society for Nursing Service Administrator's follow-up survey of its 1977 study revealed that the role of nurse executives had evolved to include increased participation in institutional governance and fiscal management and significant changes in reporting relationships.

According to Manson (1983), the nurse executive of the future must possess financial management skills, computer knowledge, marketing and public relations skills, and the ability to analyze data and formulate short and long-range plans based on economic and clinical information. Niederbaumer (1979) asserts that nursing participation in policy level decision-making is the only effective manner to plan, integrate and implement the hospital's goals.

Eventually nurse executives became involved in the process of long-range planning, and then finally in the early 1980's they began participating in the strategic planning process (Fox and Fox, 1983). Studies by Schultz (1972), Shortell, Becker and Neuhauser (1976), and Shortell and LoGerfo (1981) were the basis of Stuart's (1985) statement:

Based on the research of participation by physicians, administrators and trustees in hospital decision-making, one might expect that increased participation by nursing would be associated with positive outcomes for hospital effectiveness and viability through increasing
the organization's command of its internal environment and resources. Thus suggested outcomes might include decreased hospital costs and improved quality of nursing care through the retention and commitment of a professional nursing staff (p. 53).

Involvement in strategic planning offers nurse executives a method to increase professional practice and autonomy through participation in hospital decision making. For nursing, attaining autonomy means being able to define the domain of nursing, being able to exercise control over nursing practice and becoming more independent of medical dominance (Stuart, 1985).

Today's environment of increasing technology, escalating costs, consumer desire for additional community services, increased competition, emergence of for-profit health care organizations, and enactment of prospective payment has resulted in changing roles of health-care organizations. The evolving roles of health care organizations have in turn mandated alterations in the role of the nursing administrator (Hospital Topics, 1979). There is a need for executive nurses and their subordinates to plan for the future, which should include the construction of effective economic controls for nursing (Swansburg, 1979; Monte, 1979; Poulin, 1984).

Strategic planning offers nurse executives a method to increase management effectiveness by matching departmental strengths with environmental opportunities. It can increase
effectiveness by delineating competencies which will promote professional nursing practice, the mission, and the long-range goals of the hospital. Strategic planning permits nurses to provide services that accurately align current and potential client needs with nursing's unique professional competencies (Fox and Fox, 1983; Lukacs, 1984). Strategic planning also promotes the managerial flexibility necessary to respond proactively to new information, thereby increasing long-term viability of organizational contributions and programs (Camillius, 1980). The proactive nature of strategic planning can assist nursing in avoiding future problems; because when using the process, the executive nurse considers both what nursing currently is and should be over the projected planning period.

The purpose of this study is to determine the extent to which executive nurses in Virginia hospitals are: (a) participating in the strategic planning process for their institutions, and (b) using the strategic planning process for the department of nursing. Results of this study will provide hypothesis generation for future research, practical guidelines for future education of nurse executives and hospital administrators, practical guidelines for incorporating the strategic planning process in the department of nursing, and knowledge to practicing nurse executives regarding the
current state of their peers' involvement in strategic planning for both the hospital and the department of nursing.

Statement of the Problem

The intent of this study is to determine the extent to which nurse executives are participating in the institutional strategic planning process. A second purpose is to determine whether or not the nurse executive is using the strategic planning process in managing the department of nursing.

Research questions to be studied are:

1. To what extent are nurse executives participating in institutional strategic planning?
2. Are nurse executives using the strategic planning process in managing the department of nursing?
3. Does hospital size, ownership, or the nurse executive's educational level have any impact on extent of participation?

Operational Definitions

Executive nurse - the hospital's top nursing administrator who is responsible for directing nursing service for the entire hospital. Usual titles include Director for Nursing Service, Vice President for Nursing Service, or Assistant Administrator.

Strategic planning - the existence of a planning process for a time period of three to five years that is based on the
examination of the hospital's mission and environmental analysis; includes a listing of ranked objectives, and specific plans to achieve stated objectives, as determined by tabulating "yes" responses to questions on the participation questionnaire.

**Extent of participation** - the amount of participation in various strategic planning process activities as measured by positive responses on the strategic planning process questionnaire.

**Short-term hospitals** - hospitals in which the patient's length of stay is 30 days or less.

**Conceptual Framework**

Like other organizations, hospitals are influenced by their external and internal environments. According to Georgopoulos (1974:3), the hospital as an organization is a specialized community institution that is operating: (a) under the constraints of a health care delivery system that is invested with problems, and (b) within a turbulent social environment to which it must constantly relate and adapt. It is a highly complex organization founded on the mutual cooperation of a large and heterogenous number of inter-dependent professional, semi-professional, and nonprofessional members.
Changes in the role of the hospital as a health care center within the overall care delivery system have been noted (Georgopoulos, 1974). This redefinition of roles is occurring in the context of major societal trends concerning community demands, national health priorities and goals, and health care conceptions by both the public and its representatives (Georgopoulos, 1974).

With the advent of accelerated post-Medicare cost increases, national health policy has essentially been modified from one promoting equal access to health care to one of equal access under cost control measures. The National Health Planning and Resources Development Act of 1974 was one such cost control measure. For example, P.L. 93-641 through certificate of need requirements, attempted to curtail the costs of health care by restricting unnecessary expansion of health care facilities. Unnecessary expansion and services were restricted by placing legal prohibitions on unnecessary capital investment, and establishing financial controls by making an institution's eligibility to receive capital or operating funds dependent upon the approval of designated planning agencies (Salkever and Brice, 1976). Additional legislation in the form of prospective payment in 1983 provided financial cost control incentives to health care institutions through prospective reimbursement for hospitalized Medicare patients. These legislative acts comprise only one
element in the hospital's external environment.

Organizations may be viewed from Chin's (1961) system theory in which change is an ongoing and dynamic process caused by interactions between all the elements both internal and external to the organization. Internal elements for a hospital include such items as the number, type and educational level of personnel, condition and adequacy of physical facilities, inter- and intra-departmental relationships, type and quality of professional services being provided, operating funds, and institutional reputation. A hospital's external environment is comprised of elements arising from the political, social and economic arenas such as competition, local, state and federal regulatory requirements, availability of supplies and equipment, new technology, and societal demands for high quality and cost contained health care. All systems have inputs, transformation processes and outputs.

For input, organizations bring in a variety of material and nonmaterial resources and facilities from the environment. Hospitals import, combine and then transform such inputs as new personnel, technology, knowledge, and equipment into outputs such as advanced technology, additional knowledge, expanded services and improved health care. Organizations import raw materials, supplies, equipment, funds, labor, and information in order to reduce uncertainty and
fight entropy—the trend for systems to become disorganized, break down and disintegrate.

Organizations import the above resources and transform inputs into outputs. Organizational outputs vary according to the purpose of the organization. For manufacturing organizations, they are usually physical products like watches or cars. Educational and research organizations provide educated individuals and new information as their output. The third type of system, service organizations, produce various services to society, such as health care.

An organization is an open system because there is a constant exchange of information, matter, and energy between the organization and its environment. The open system is in continual interaction with its environment and achieves a "steady state" or a dynamic equilibrium while still retaining its capacity for work or energy transformation. The organization balances maintenance activities such as purchase, maintenance of equipment, recruitment and training, and rules and regulations with adaptive activities of planning, marketing, and research and development (Robbins, 1983:12). The open system adapts to its environment by changing the structure and processes of its internal components.

Human organizations are constantly subject to external forces, pressures, and stimuli that significantly influence behavior within the system, and vice versa (Georgopoulos,
During the process of simultaneous stimulation, organizations are affecting the environment and are in turn affected by it. Through continual interchange and negotiation with the environment organizations preserve their basic integrity and internal adjustment while coping with external change. Human organizations are dynamic open systems, whose boundaries are relatively elastic and permeable rather than fixed. They are sufficiently open to allow the input-output transformations of matter, energy and information with the external environment that are vital to the existence and functioning of the system.

The hospital as a human organization is an open system which is influenced by many different sectors in the external environment. In return, the hospital influences the external environmental sectors, primarily through political and client interaction processes. The hospital is also influenced by its internal environment such as the quality, productivity, and efficiency of its professional staff, and influences its professional staff through the enactment of performance standards, bylaws, and reward systems. Because the hospital is an open system there is constant interaction between it and its environments.

Strategic planning is one method for effectively managing the organization's open system environment in which change is an ongoing and dynamic process secondary to
interactions among elements both internal and external to the organization. The process of strategic planning includes the assessment of the external and internal environments, establishment of goals, formulating alternatives for achieving the goals, selection and implementation of strategic choices and ongoing evaluation and adaptation as new information becomes available. For example, if a hospital has a low occupancy rate, its medical staff is primarily general practitioners, and the community lacks skilled nursing beds, the hospital might consider opening a skilled nursing unit for patients who no longer require acute hospital care, but who are not ready to be discharged to home or to a long-term care facility. By focusing on the institution's strengths and weaknesses in combination with threats and opportunities presented by the external environment, strategic planning enables a hospital to link the organization with its external environment.

Because the hospital is an open systems environment, nursing can contribute to the institutional strategic planning and employ the strategic planning process in managing the boundary between nursing, the hospital and the community. Nurse executive involvement in the strategic planning process can enhance professional practice and autonomy while simultaneously contributing to the organization's efficiency and effectiveness.
CHAPTER TWO

Literature Review

Planning in Business Organizations

Participation in strategic planning by organizations began in the manufacturing industry and was later adopted by service industries. Bourgeois (1980:27) asserts that among the many definitions of strategy two primary purposes can be identified: (a) "define the segment of the environment in which the organization will operate," and (b) "provide guidance for subsequent goal-directed activity within that niche."

Steiner (1979:37) states that strategic planning has seven elements: (a) it simulates the future, (b) it applies the systems approach, (c) it forces the setting of objectives, (d) it reveals and clarifies future opportunities and threats, (e) it provides a framework for decision-making throughout the company, (f) it is a basis for other management functions, and (g) can be used to measure performance.

However, Steiner (1979:37) also identifies some limitations of strategic planning: the environment may prove different from that anticipated; there may be internal resistance; planning is expensive and does not manage crises. In addition, planning is difficult, and completed plans can limit choice. Kiechel (1982) after reviewing actual actions
to planned strategies, estimated that 90 percent of all American companies had failed to successfully implement their strategies.

In the middle 1950's many American firms experienced a leveling off of their market demand, a decreased demand secondary to substitutive products by new technologies and increased market share by foreign competitors (Ansoff, et al., 1976:41). Additional environmental changes affecting industry included anti-trust legislation, safety legislation, consumer pressures, pollution constraints, and price and wage controls. Manufacturing firms, followed by other types of organizations, increasingly became concerned about their "mal-adjustment with the environment." The cause, which was labeled the "strategic problem," was thought to be secondary to a techno-economic mismatch between the products of the firm and the demands of its market (Ansoff, et al., 1976:1).

Strategic planning was developed as a solution. Strategic planning was formulated to furnish management a tool that would enable a rational analysis of both the threats and opportunities provided by the environment and the strengths and weaknesses of the firm. The analysis would then be followed by a selection of a "match" or strategy between the firm and its environment which would meet the objectives of the firm (Ansoff, et al., 1976:11).
Initially, strategic planning included only the technological, economic and informational variables; excluded were the political and social dynamics both internal and external to the organization. Ansoff, et al. (1976), however, predicted that psychological, social and political variables would become the most important variables in the 1980's. Because of the importance of the excluded variables, they were eventually included as a total package in the strategic management process.

In 1982, Armstrong conducted a review of empirical research to determine the value of formal planning for strategic decisions. He examined 12 studies to determine what aspects of formal planning were actually used, in what situations formal planning was used, and what the results of formal versus informal planning were. Several difficulties were encountered. First, 60 percent of the studies did not provide adequate information on the nature of the planning process. Second, 70 percent of the studies did not include information to determine the situation in which formal planning was used, and finally, 80 percent of the studies limited the results of strategic planning only to the financial impact of planning upon the stockholder's return on investment, rather than evaluating the entire efficiency of the firm. However, in spite of the limitations, a pattern could be identified. When improved performance was used as the
evaluating criteria, informal planning was superior in two comparisons, but neither was statistically significant; formal planning was superior in 10 of 15 comparisons in the 12 studies, with five comparisons being statistically significant. It was also noted that formal planning tended to be more useful where major changes such as new product introductions or high rates of technological innovations were involved.

In reviewing the literature concerning the impact of formalized strategic planning on the financial performance of small organizations, conflicting results were found. Ansoff, Ayner, Brandenburg, Portner and Radosevich (1970) examined the influence of planning on successful acquisitions in 93 American firms from 1946-1965. Planners significantly outperformed nonplanners when using economic criteria of sales, earnings, earnings per share, and return on common equity.

Thune and House (1970) investigated the impact of long-range planning on the economic performance of 36 firms in six industries. Economic criteria used were: sales, stock prices, earnings per share, return on common equity, and return on total capital employed. Formal planners significantly outperformed informal planners in the drug, chemical, and machinery industries, but no significant relationships were found in the food, oil, and steel industries.
Herold (1972) expanded Thune and House's study by including pretax profits when measuring economic performance. Five formal planners in the drug and chemical industries outperformed five informal planners in the same industries.

Rue (1973) investigated the associations between long-range planning and the economic performance of 386 firms in the nondurable, durable, and service industries. In the durable industries, planners outperformed the nonplanners; in the service industries, nonplanners outperformed planners; but in the nondurable industries, no consistent differences were found.

Karger and Malik (1975) evaluated the impact of formal integrated long-range planning on economic performance for 38 firms in the chemical, drug, electronic, and machinery industries. Planners outperformed nonplanners on 10 of 13 economic measures, including net income, sales, earnings per share, and return on net worth.

Robinson and Pearce (1983), in the study of 50 small United States banks, also found empirical support for a positive relationship between strategic planning and performance in large organizations. However, there were also some contradictions noted in two studies.

First, Grinyer and Norburn (1975) investigated the relationships between characteristics of the strategic planning process and financial performance in 21 United
Kingdom companies using return on net assets as the measure of profitability. They were unable to find a significant relationship between formal strategic planning and financial performance.

Second, Kudla (1980) investigated the effects of strategic planning on returns to shareholders in 328 companies. No significant differences in returns to shareholders by planning and nonplanning firms were found.

Methodological concerns were expressed regarding the negative studies, i.e., those studies which did not support the beneficial impact of formal planning. Kudla (1980) discovered in previous studies that no attempt had been made to control for extraneous independent variables, such as general market conditions, industry differences, and government factors, which could have affected the outcome of the studies. These studies also did not control for inter-industry differences. Rue (1973) found no significant differences between planners and nonplanners in the nondurable industries, but that nonplanners outperformed planners in service industries. Leontiades and Tezel (1980) expressed concern that the methods for operationalizing formality of strategic planning in previous studies had been too simple, arbitrary, and reflected the researcher's opinion rather than the true character of the planning system, i.e., whether or not the planning system was really one of strategic planning.
An additional concern regarding the studies, regardless of whether the results were positive or negative, was that the samples were of large organizations. Lindsay and Rue (1980) discovered that there were significant differences between the organizational environment of large and small firms, and therefore it was necessary to control for this. They found that firms tended to adopt more complete formal long-range planning processes as the complexity and instability of the business environment increased. Lindsay and Rue stated:

Another finding was that the degree of openness in long-range planning processes is directly related to the degree of environmental complexity for large firms, but inversely related for small firms. The evidence obtained from this study suggests that large business firms in a variety of industries are attempting to fit their long-range planning processes to their perceived environmental conditions, and that small firms should be considered as a separate class in this and future related studies (1980:402).

Lindsay and Rue (1980:402) stated that possibly:

Top management in small firms tended to centralize planning under adverse conditions and to trust more in their own judgments, but that managers in large firms tended to be more open to information from as many sources as possible.

Because the degree of openness in the long-range planning process may vary, Lindsay and Rue (1980) advise that firm size is a significant independent variable to consider when designing an effective strategic planning process.
In prescriptive literature, Buchele (1967), Cohen and Lindberg (1972), Gilmore (1971), Robinson (1980), Steiner (1967), and Still (1974) stated that outsiders, short-time horizons, minimum emphasis on goal identification, and informality were four key components of an effective small firm planning process. Robinson and Pearce (1983:198) stated that while the above variables were attributed to planning, these same variables may have reflected characteristics of flexibility, efficiency and centralized decision making which allowed small firms to survive in a particular industry segment.

Empirical research examining the relationship between strategic planning and performance in small organizations is sparse. Strategic planning improved small firm effectiveness when the systematic utilization of consultants was part of the planning process (Robinson, 1982). In 1983, Robinson and Pearce studied 20 randomly chosen small banks from a sample of 85 federal and state-chartered banks in South Carolina to determine the impact of formalized strategic planning on financial performance in small organizations. Questionnaires concerned the formality of the bank's strategic planning, and the degree to which the bank's strategic decision making incorporated six basic dimensions of strategic management commonly found in the literature. The length of time the strategic planning process had been in
place was not considered. Performance data on profit margin, return on assets, loan growth, and return on equity were obtained for three years (1977-1979) on each bank, and all banks were ranked on each performance measure.

No significant differences in performance rankings were noted on any of the four performance measures. Therefore, the performance of small banks using formal strategic planning was not significantly better than nonformal small bank planners. Formal and nonformal planners placed similar emphasis on scanning the environment, identifying distinct competencies, aligning organizational structure, deploying internal resources, and monitoring/controlling implementation in the strategic planning processes. However, formal planners placed significantly greater emphasis on concern for formulating goals and objectives than did nonformal planners. This study contradicts the findings of Wood and LaForge (1979) concerning the value of formal strategic planning in organizational performance, and suggests that there may be different determinants of effectiveness in small firms.

Planning in Hospitals

Strategic planning has only recently come to the hospital industry. To investigate the nature of existing long-range planning efforts, Perlin, in 1972, conducted a nationwide survey of 614 nonfederal, short-term, general hospitals. Perlin (1972) found that although 96 percent of
the hospitals stated they were engaged in long-range planning and two-thirds had a continuous planning process, about one-third of these efforts were one-time exercises and were not part of an ongoing process. Additionally, differences in hospital goals, organizational mechanisms, participation in the planning process, and constraints to effective planning were identified. In three-fourths of the hospitals studied, long-range planning was primarily the responsibility of the chief executive officers, most of whom spent only one-eighth or less of their time on planning (Perlin, 1972).

Prompted by legislation enacted in the 1970's, the 1980's has brought to the hospital industry a greater need for external environmental scanning. Certificate of need legislation, enacted in 1974, meant that institutions could establish new services only with an approved certificate of need granted by the Health Systems Agency (HSA). Applicants would receive grants, contracts, loans, or loan guarantees under specified federal public health programs for resource development only after approval by the HSA.

On July 7, 1972, through Medicare/Medicaid amendments, the Social Security Administration mandated limited institutional planning as a requirement for participation. Under P.L. 92-603, hospitals were required to prepare an overall plan and budget which provided for an annual operating budget and a capital expenditure plan. The capital expenditure plan
covered a three-year period and the overall plan was reviewed and updated annually.

Regardless of the legislation enacted, many hospitals continue to be involved in little, if any, comprehensive strategic planning. Mankin and Glueck (1977), surveying 15 Missouri hospitals, reported that only 40 percent of hospital administrators systematically appraised the external hospital environment. Bander (1980) surveyed 10 urban, not-for-profit hospitals and found that only two hospitals were actively utilizing strategic planning. Breindel (1980) reviewed the planning process of 71 Virginia hospitals. He found that 38 percent did not have long-range plans, and of those institutions having long-range plans only 5.6 percent had a formal organized planning department.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) restricted the growth rate in hospital costs, as measured against an institution-specific base-year cost. The following year, additional legislation phased out the TEFRA provisions for acute care hospitals and introduced a new system that over a three-year period shifted hospitals from regional to national peer-group rates. In 1984, new regulations reduced the permitted annual increase in regional and national peer-group rates to a level below that expected by many hospitals (Anderson, 1985).
In 1983, prospective payment for Medicare was instituted. All hospitals, except for psychiatric, long-term care, pediatric, and rehabilitation hospitals, are paid a fixed amount determined in advance for each case in a diagnosis related group (DRG). Hospitals cannot claim higher DRG payments or charge beneficiaries more than the statutory deductible or coinsurance; but if the hospital's operating expenses are lower than the payment, the hospital may keep the difference (Davis, 1983). In addition to various legislative enactments, the hospital industry itself has been changing and becoming increasingly competitive. Health maintenance organizations are an example of this competitiveness.

In the 1930's Kaiser developed the health maintenance organization (HMO), which is a prepaid group practice health care delivery system. In 1983, HMO's served six percent of the population (Friedman, 1984). However, with the enactment of prospective payment in 1983, industry's concern with the cost of health benefits, and greater cost sharing by consumers, the number and memberships in HMO's are expected to increase.

During the 1960's, hospitals saw the entry of major proprietary chains. The advantages of proprietaries listed by CEO's are "management based on the industry model, corporate structure and diversification of product lines, the ability to make rapid decisions, an access to large amounts
of capital, and the use of marketing research" (Sussman, 1985:23). Although the number of hospitals in the United States has remained fairly consistent, in the past decade the number of hospitals which are affiliated with investor-owned chains has increased by 80 percent (Watt, Derzon, Renn, Schramm, Hahn and Pillari, 1986). Finally, the growing trend of multi-institutional hospital firms, for-profit institutions, increased use of ambulatory care centers and the increased number of aged have all contributed to the necessity for increased external environmental scanning by health care facilities.

Pitts and Wood (1985) reviewed and critiqued the strategic management literature on not-for-profit community hospitals. They found that over half of the articles were prescriptive in nature: in other words, there was no empirical evidence to support the positive impact of strategic management in community not-for-profit hospitals. Several studies found by Pitts and Wood that a large percentage of hospitals had strategic plans, but as of 1982 Kropf and Goldsmith (p. 5) "noted a minimal use of sophisticated analytical techniques along with little innovation in hospital plans." Pitts and Wood found no studies that correlated the value of strategic planning with performance or the appropriateness of specific strategies.
In 1983, Pitts studied 34 Virginia hospitals to determine whether or not planning changed performance. Performance was viewed from the perspective of occupancy rate, personnel expense per operating bed, total expense per operating bed, number of personnel per operating bed, and relative market share. Strategic planning intensity was determined by total scores on the questionnaire. Areas addressed in the questionnaire were: the existence of a written plan, the plan's contents, the existence of a planning department, a staff planner, and a board and/or administrative planning committee. Pitts found that 70.8 percent of the hospitals had long-range plans; most of the hospitals had plans for the past five years; plans usually were generated for three to five years; and the plans were updated yearly.

Weaknesses identified by Pitts in the long-range plans were: lack of plan content, lack of goal documentation, lack of a marketing plan, and only 29 percent had a financial plan. Typically, the planning document was done internally and approved by the board of trustees. The size of the hospital had little relationship to planning. Employees had some input into the plan but little access to the completed document and the chief executive officer was the main player.

Additional findings were that urban high formal planners, as measured on a planning intensity scale, were
better at controlling expenses, while urban less formal planners gained more market share. Rural less formal planners, as measured on a planning intensity scale, were better at controlling expenses, while rural more formal planners gained more market share. High implementation and formal planners never produced the highest performance. Changes in the environment did cause changes in planning, but not necessarily better planning. Planning had little effect on marketing and no effect on occupancy. Pitts' study clearly demonstrated that strategic planning is being done in the majority of Virginia community hospitals. However, a clear link to formal planning and high performance was not demonstrated. Therefore, while industry studies have demonstrated a positive effect on performance through the use of the strategic planning process, hospital studies have not as yet demonstrated such a direct effect.

Nurses Participation in Planning

Nursing administrators have often been promoted into their executive positions with little or no previous management experience or training (Stein, 1980) and have lacked the knowledge and experience necessary to implement formal planning processes (Fox and Fox, 1983). Lack of knowledgeable expertise combined with nonrecognition of DNSs by both peers and CEOs as a valuable contributor to planning, delayed executive nurses' involvement in formalized planning. The
extent to which executive nurses have been participating in strategic planning has been discussed in the literature for approximately the last five years.

In 1971, Poulin investigated how nurse executives "viewed their positions in an increasingly complex and changing situation" (1984:9). In 1980, Poulin replicated her study and investigated "the structural and functional components of the nurse executive's position as perceived by selected incumbents" (1984:9). A nonrandomized sample of 12 nursing administrators was selected based on their peers' recognition of the nurse executives' administrative competence and/or reputation for progressive delivery of nursing care. A profile of these nursing administrators emerged: a single woman between the ages of 50 and 59 years, has a master's degree, has been in her present position for 5.3 years, has been in nursing for 25 years, employed in a general hospital of 400 to 599 beds, assisted by 11 employees reporting directly to her, reports directly to the chief executive officer, and holds a corporate title that places her at the top level of the organizational hierarchy. The majority listed the chief executive officer as the person who most influenced them in their present position. The executive nurses stated that their primary responsibility in nursing care was: "(a) the setting and implementation of standards and goals, (b) ensuring control mechanisms,
(c) provision of personnel, and (d) the facilitation of staff functioning" (1984:11). Respondents identified their main responsibility in personnel functions as the development and dissemination of policy, particularly the development of budget and salary scales. Terms which reflected a change from centralized nursing to decentralized included self-governance committees, task forces, individualized career development, leadership development and head nurse decisions. Educational responsibilities were also considered an integral part of the nurse executive role. Participants functioned as preceptors for students, taught classes, were guest lecturers, and were members of advisory councils to schools. Responsibility for nursing care had broadened from inpatient care to ambulatory care, home health agencies, alcohol rehabilitation, outreach programs, and nursing departments of other facilities. Outside of the nursing department, executive nurses were involved with the hospital's budget and policy development and interdepartmental relations.

Based on the taped interviews with the 12 nursing administrators, Poulin (1984) reached five conclusions which can be related to organizational-environmental boundaries. First, the scope and responsibility of the executive nurse was shifting from a focus on the internal direction of nursing service to a broad social concern for meeting the
nursing needs of society. Second, the degree of authority nursing has and the influence it exerts in the hospital's total program are directly related to the executive nurse's position in the organizational hierarchy. Third, the executive nurse deals with a variety of individuals and groups outside the nursing directorate, resulting in a complex pattern of interactional behaviors. Fourth, the role of the executive nurse in the organization's power structure will change from a medically based to a multiprofessionally based system to accommodate a broader spectrum of health services in keeping with consumer demands. Fifth, if present trends continue, the role of the executive nurse will become more coordinating and less directing as the organization becomes more decentralized and nursing becomes more professionalized.

In 1982, the American Society for Nursing Service Administrators surveyed 361 of its members to update its 1977 Survey of Nursing Service Administrators. Of particular interest were changes in salary and benefits, role, functions, responsibility, and accountability that had occurred since 1977. In 1977, "director of nursing" was the most frequently used title (77.1%), and 1.6 percent of executive nurses were titled "vice president." The title "assistant administrator" was not included in the 1977 survey. In 1982, however, 36.7 percent of nurse executives used the title of "director of nursing," followed by "assistant administrator"
(19.1%), and "vice president for nursing" (17.3%). Aydelotte also found that 21 percent of nurse executives participated in hospital governance, of these 3.9 percent were voting members of the governing board. Half of the nurses surveyed were members of board committees and were members of the Medical Executive Committee, with eight percent being voting members. Nursing service administrators reported to the top administrative officer 81.6 percent of the time, with 14 percent reporting to the second level. Nursing administrators participated in planning the overall hospital budget in 82.6 percent of the institutions as compared to 50.8 percent in 1977. Seventy-seven percent of nurse administrators assisted in establishing budget priorities in 1982 as compared with 48 percent in 1977. Ninety-three percent of the nurse administrators established the nursing budget in 1982 as compared to 56.1 percent in 1977. The evolving role of the nurse executive is reflected by increased participation in institutional governance and fiscal management, and through significant changes in reporting relationships.

In Simms, et al. (1985) study to determine precise functions of nurse executives and how they differ among practice settings, 30 nurse executives were interviewed. Twenty of the 30 administrators in acute care hospitals and home-care institutions held master's degrees. These 20 nurse administrators were all involved in long-range planning, financial
management and policy-making. The sample of 30 nursing administrators were employed in a variety of institutions: 10 were in acute care institutions (five from 200-500 bed institutions, five from greater than 500 beds). Ten nursing administrators were employed by home care agencies which served approximately 100,000 people; and 10 nursing administrators were from long-term facilities with over 100 beds. Simms' sample is not truly representative of nurse administrators in general because the average hospital is about 150 beds. Also in 1985, R. M. Anderson stated that of 61,000 nurses in administrative positions across the United States, only 18 percent had master's degrees as compared to Simms, et al.'s 66 percent.

As cited in Aydelotte's repeat study of 1982, the majority of nurse executives are establishing their own departmental budgets and assisting with developing the hospital's budget as well as taking a more active role at the executive administrative level for the hospital. Stuart (1985), in her study of participation in hospital decision making by nurses, demonstrated that nurse administrators desired greater participation in top level decision making. However, the question of the extent to which executive nurses are participating in organizational-environmental boundary management through strategic planning has not been answered.
CHAPTER THREE

Methodology

The purpose of this study was to determine the extent to which nurse executives are participating in the institutional strategic planning process. A second purpose was to determine whether or not the nurse executive is using the strategic planning process in managing the department of nursing.

Research questions which were studied included:

1. To what extent are nurse executives participating in institutional strategic planning?
2. To what extent are nurse executives using the strategic planning process in managing the department of nursing?
3. Does hospital size, ownership, or the nurse executives' educational level have any impact on extent of participation?

Design

A descriptive ex post facto design was used for this study. According to Polit and Hungler (1983):

The basic purpose of ex post facto research is essentially the same as experimental research: to determine the relationships among variables. The most important distinction between the two is the difficulty in inferring causal relationships in ex post facto studies because of the lack of manipulative control of the independent variable (p. 170).
The nature of the independent variables of ownership, size, and nurse executive educational level were not able to be manipulated.

The weaknesses of ex post facto research (Kerlinger, 1973) include: (a) the inability to actively manipulate the independent variables, (b) the inability to randomly assign individuals to experimental treatments, and (c) the possibility of faulty interpretation of study results.

Design strengths include the ability to collect large amounts of data in an efficient and effective manner, its use in field settings, and the appropriateness of its use in many health related studies where manipulation of variables would be unethical or impractical (Polit and Hungler, 1983: 181-183). This design was selected both because it enabled large amounts of data to be collected within the hospital and because manipulation of the independent variables was impractical.

While this is not a quasi-experimental design, threats to validity include inexperience of the researcher, instrument problems, and that the findings of extent of participation in strategic planning may not be generalizable to non-short-term health care institutions.

**Population and Sample**

To study the question regarding extent of participation by Virginia executive nurses in strategic planning, all
Virginia Hospital Association executive nurses were asked to participate in the study. By including all Virginia hospital executive nurses, the hospitals represented various sizes and types, both proprietary and nonproprietary, as well as teaching and nonteaching institutions.

The target population consisted of all Virginia acute care hospital executive nurses. The accessible population, short-term hospitals, was drawn from a list of hospitals which were members of the Virginia Hospital Association. All short-term hospitals were included in the study. Nurse executives of short-term care hospitals (i.e., with lengths of stay less than 30 days), with the title of Director of Nursing Service, Vice President for Nursing, or Assistant Administrator, who were members of the Virginia Hospital Association comprised the accessible population.

**Data Collection Procedure**

A list of Virginia short-term care hospitals was obtained from the Virginia Hospital Association. All short-term care Virginia hospital nurse executives were asked to participate. In order to insure confidentiality, questionnaires were numbered in the same order as the researcher's list of executive nurses who were being requested to participate in the study. Coded questionnaires with cover letters explaining the purpose of the study were sent to Virginia executive nurses; returned
completed questionnaires signified participation consent. Responses of returned questionnaires were tabulated and data analyzed.

A mailed survey was chosen because of the large geographic area involved in the study and time constraints of the researcher. Strengths of a mail survey include expediency of gathering data from a large sample. In addition, the anonymity of the mail survey increases the freedom of the respondent to answer questions. The weaknesses of a mail survey include lower response rate, sometimes resulting in response bias (Babbie, 1973). Another weakness is the possibility of superficial responses in comparison to data collected in personal interviews. These weaknesses may make generalizing the results of the study inappropriate. When a low response rate is experienced, if respondent geographic characteristics are similar to the target population characteristics, the presence of a serious bias can be negated (Babbie, 1973).

Development of Survey Instrument

In order to measure the extent of participation in strategic planning and the use of the strategic planning process in the department of nursing, a scale based instrument was chosen as the best tool to assess the range of participation. Because the strategic planning process is relatively new to
the hospital industry, an instrument which allowed a range of responses rather than an all or none response was deemed more appropriate for the research. The value of such a format is the "unambiguous ordinality of response categories" (Babbie, 1973:269). A scale confines the respondent to a set of responses and allows the researcher to evaluate the relative strength of participation. The Likert method is founded on the assumption "that the overall score based on responses to the many items, seeming to reflect the variable under consideration, provides a reasonably good measure of the variable" (Babbie, 1973:270). Overall scores can be used to analyze individual items in order to determine the best indicators of the variable; and only these items are included in the index ultimately used for analyses of the variable.

For this study a Likert scale was employed with the range of responses of: 1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, and 5 = to a very great extent. Scores were totalled and averaged for each section relating to strategic planning for both the institution and the department of nursing (sections II A-F and III A-F).

After the tool was formulated by the researcher, content and face validity were established by nurse and hospital administration strategic planning experts reviewing the instrument. Following incorporation of suggested changes, the instrument was again reviewed by the thesis committee; and
after approval, the questionnaire was mailed to all Virginia hospital nurse executives. No quantitative measures of reliability or validity were calculated.

The following section provides information regarding which questions were used to determine participation in each segment of the strategic planning process.

**Extent of Participation in Hospital Strategic Planning**

The extent of participation was determined by analyzing the executive nurse's involvement with the five phases of strategic planning (Luke and Kurowski, 1983).

**Environmental analysis** involves both the external and internal environments.

**External environmental analysis** refers to scanning the environment for threats and opportunities to the hospital (Mankin and Glueck, 1977). Extent of participation in hospital external environmental analysis is assessed with items II, Section A, questions 1-4.

**Question 1:** To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national economic environment which could influence the way business is conducted, or the services which are offered? For example: information might relate to new insurance coverage, reimbursement rates for third party payers or the opening/closing of a community industry.
**Question 2:** To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national political environment which could influence the way business is conducted, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or a local competitor's plans for a new service or facility.

**Question 3:** To what extent do you participate in gathering and analyzing information regarding changes in health care and/or information management system technology which could influence the way business is conducted or the services which are offered? For example: installation of an automated patient care information system, or the need for home health care services.

**Question 4:** To what extent do you participate in gathering and analyzing information regarding the local, state, and/or federal social policy which could influence the way business is conducted or the services which are offered? For example: minority needs, community activities, or consumer profiles.
Internal environmental analysis refers to elements and conditions present in the institution itself which comprise institutional advantages and disadvantages (Mankin and Glueck, 1977; Luke and Kurowski, 1983). Extent of participation in hospital internal environmental analysis is assessed with items II, Section B, questions 1-6.

**Question 1:** To what extent do you participate in gathering and analyzing information regarding the hospital's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel.

**Question 2:** To what extent do you participate in gathering and analyzing information regarding the financial status? For example, hospital's income and balance sheets, financial ratio analysis, or cost containment measures.

**Question 3:** To what extent do you participate in gathering and analyzing information regarding productivity? For example: variance analysis.

**Question 4:** To what extent do you participate in gathering and analyzing information regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.
Question 5: To what extent do you participate in gathering and analyzing information regarding the hospital's current health care delivery, or its existing information management system's technology. For example: new products/procedures, or additions to or replacement of the current information management system.

Question 6: To what extent do you participate in reviewing and revising the hospital's mission statement?

Formulating goals and objectives refers to establishing goals and objectives or priorities that the hospital wants to achieve based on matching the hospital's strengths with environmental opportunities (Mankin and Glueck, 1977; Luke and Kurowski, 1983). Items which assess participation in formulating goals and objectives or establishing priorities for the hospital are in II, Section C, questions 1-6.

Question 1: To what extent do you participate in formulating goals/objectives based on the hospital's internal environmental analysis?

Question 2: To what extent do you participate in formulating goals/objectives based on the hospital's external environmental analysis?
Question 3: To what extent do you participate in ranking the goals/objectives?

Question 4: To what extent do you participate in formulating priorities based on the hospital's internal environmental analysis?

Question 5: To what extent do you participate in formulating priorities based on the hospital's external environmental analysis?

Question 6: To what extent do you participate in ranking the priorities?

Strategic analysis and choice refers to considering strategic alternatives and choosing the strategy(ies) (Mankin and Glueck, 1977). Items addressing strategic analysis and choice for the hospital are in II, Section D, questions 1-4.

Question 1: To what extent do you participate in formulating possible strategies for the hospital's long-range plan?

Question 2: To what extent do you participate in analyzing the costs/benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/objectives/priorities?
**Question 3:** To what extent do you participate in evaluating the **advantages** and/or **disadvantages** of proposed strategies relevant to the resources, competence and preferences of the organization?

**Question 4:** To what extent do you participate in **selecting** from the proposed strategies the **strategic choice(s)** which will be implemented?

**Strategy implementation** refers to developing policies, plans and assigning human, material, financial, and ideational resources required by the strategy (Mankin and Glueck, 1977). Items which assess participation in hospital strategy implementation are contained in II, Section E, questions 1-4.

**Question 1:** To what extent do you participate in **developing policies** for implementing the strategic choice(s)?

**Question 2:** To what extent do you participate in **developing plans** for implementing the strategic choice(s)?

**Question 3:** To what extent do you participate in **identifying individuals** who will be responsible for implementing the strategic choice(s)?
Question 4: To what extent do you participate in selecting individuals who will be responsible for implementing the strategic choice(s)?

Strategy evaluation refers to participation in assessing the success for implementing the strategy and the success of the strategy in meeting the institution's goals, objectives or priorities (Mankin and Glueck, 1977). Items which address hospital strategy implementation are contained in II, Section F, questions 1-4.

Question 1: To what extent do you participate in developing performance measures for monitoring and controlling implementation of the strategic choice(s)?

Question 2: To what extent do you participate in analyzing the performance measures' results?

Question 3: To what extent do you participate in evaluating the success of implementing the strategic choice(s)?

Question 4: To what extent do you participate in re-evaluation of current goals/objectives, priorities, and strategies in light of new elements in the external or internal environments, or a change in the mission?
Strategic Planning Process Use by the Executive Nurse

The extent of strategic planning process use for the department of nursing was determined by analyzing the executive nurse's utilization of the five phases of strategic planning (Luke and Kurowski, 1983):

Environmental analysis involves both the external and internal environments.

External environmental analysis refers to scanning the environment for threats and opportunities to the department of nursing (Mankin and Glueck, 1977). Utilization of external environmental analysis is assessed with items III, Section A, questions 1-4.

**Question 1:** When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national economic environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: information might relate to new services or procedures which the hospital or department of nursing could offer, direct reimbursement for nursing services, or separation of nursing service charges from hospital bed and board charges.
**Question 2:** When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national political environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or changes in the nurse practice act.

**Question 3:** When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding changes in health care and/or information management system technology which could influence the way the department of nursing conducts its business or the services which are offered? For example, improvement of automated nurse staffing and scheduling systems, or the need for home health services.

**Question 4:** When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national social policy which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: minority needs, community activities, or consumer profiles?
Internal environmental analysis refers to elements and conditions present in the department of nursing itself which comprise nursing advantages and disadvantages (Mankin and Glueck, 1977; Luke and Kurowski, 1983). Use of internal environmental analysis is assessed with items III, Section B, questions 1-6.

**Question 1:** When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the department of nursing's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel?

**Question 2:** When preparing nursing's long-range plan, to what extent do you gather and analyze information for the department of nursing regarding its financial status? For example: variance analysis, number of patient care hours needed per patient classification category, or skill mix.

**Question 3:** When preparing nursing's long-range plan, to what extent do you gather and analyze information for the department of nursing regarding its productivity? For example: variance analysis.
Question 4: When preparing nursing's long-range plan, to what extent do you gather and analyze information for the department of nursing regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.

Question 5: When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the nursing department's current health care delivery, or its existing information management system's technology? For example: new products/procedures, or additions to or replacement of the current information management system.

Question 6: When preparing nursing's long-range plan, to what extent do you review and revise nursing's mission statement?

Formulating goals and objectives refers to establishing goals and objectives or priorities that the nursing department wants to achieve based on matching nursing's strengths with environmental opportunities (Mankin, et al., 1977; Luke and Kurowski, 1983). Items which assess utilization of formulating goals and objectives or establishing priorities for the nursing department are in III, Section C, questions 1-6.
Question 1: When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's internal environmental analysis?

Question 2: When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's external environmental analysis?

Question 3: When preparing nursing's long-range plan, to what extent do you rank the goals/objectives for the department of nursing?

Question 4: When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's internal environmental analysis?

Question 5: When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's external environmental analysis?

Question 6: When preparing nursing's long-range plan, to what extent do you rank priorities?

Strategic analysis and choice refers to considering strategic alternatives and choosing the strategy(ies) (Mankin and Glueck, 1977). Items addressing strategic analysis and choice for the nursing department are in III, Section D, questions 1-4.
Question 1: To what extent do you formulate possible strategies for nursing's long-range plan?

Question 2: To what extent do you analyze the costs/benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/objectives, and priorities?

Question 3: When preparing nursing's long-range plan, to what extent do you evaluate the advantages and/or disadvantages of the proposed strategies relevant to the resources, competence, and preferences of the organization?

Question 4: When preparing nursing's long-range plan, to what extent do you select from the proposed strategies the strategic choice(s) which will be implemented?

Strategy implementation refers to developing policies, plans and assigning human, material, financial, and ideational resources required by the strategy (Mankin and Glueck, 1977). Items which assess utilization of strategy implementation for the department of nursing are contained in III, Section E, questions 1-4.

Question 1: When preparing nursing's long-range plan, to what extent do you develop policies for implementing the strategic choice?
Question 2: When preparing nursing's long-range plan, to what extent do you develop plans for implementing the strategic choice?

Question 3: When preparing nursing's long-range plan, to what extent do you identify individuals who will be responsible for implementing the strategic choice?

Question 4: When preparing nursing's long-range plan, to what extent do you select individuals who will be responsible for implementing the strategic choice?

Strategy evaluation refers to assessing the success both of implementing the strategy and the success of the strategy in meeting nursing's goals, objectives or priorities (Mankin and Glueck, 1977). Items which address strategy implementation are contained in III, Section F, questions 1-4.

Question 1: When preparing nursing's long-range plan, to what extent do you develop performance measures for monitoring and controlling implementation of the strategic choice(s)?

Question 2: When preparing nursing's long-range plan, to what extent do you analyze the performance measures' results?
Question 3: When preparing nursing's long-range plan, to what extent do you evaluate the success of implementing the strategic choice(s)?

Question 4: When preparing nursing's long-range plan, to what extent do you re-evaluate current goals/objectives, priorities, and strategies in light of new elements in the external and internal environments, or a change in the mission?

Hospital Demographic Data

Hospital demographic data was obtained for correlation with the strategic planning process for both the institution and the department of nursing. Demographic data concerning the hospital's size and ownership are contained in items I, A and B.

Item IA: Your hospital is:

____ 0-99 beds
____ 100-399 beds
____ 400 beds or more

Item IB: Your hospital is classified as:

____ nonprofit
____ for profit

Demographic data concerning the hospital's planning process and the content of the plan is contained in items I, C-H.
Item IC: Does your hospital have a long-range plan?

Item ID: If your hospital has a long-range plan, is it written?

Item IE: What is the time period covered by the long-range plan?

___ less than 3 years  ___ 5 years
___ 3 years          ___ greater than 5 years
___ 4 years

Item IF: Which of the following are included in the long-range plan?

___ mission statement
___ master facilities plan
___ financial plan
___ capital budget
___ marketing plan
___ operating budget
___ contingency plan
___ external environment analysis
___ internal environment analysis
___ formulating goals/objectives
___ formulating priorities
___ ranking goals and objectives
___ ranking priorities
___ formulating strategies to meet goals/objectives
___ formulating strategies to meet priorities
___ selecting strategies
___ implementing strategies
___ evaluation

Item IG: In what year did your hospital first prepare a long-range plan? 19__

Item IH: If your hospital has a long-range plan, is it formulated similar to the process described in the definition of strategic planning process?
Nursing Department's Demographic Data

Nursing demographic data was obtained for correlation with the strategic planning process for both the institution and the department of nursing. Demographic data regarding nursing's planning process and the content of the plan is contained in items III, A-G.

Item IIIA: Does the department of nursing have a long-range plan?

Item IIIB: Is the department of nursing's long-range plan written?

Item IIIC: What is the time period covered by the long-range plan?

- [ ] less than 3 years  [ ] 5 years
- [ ] 3 years  [ ] greater than 5 years
- [ ] 4 years

Item IIID: In what year did the department of nursing first prepare a long-range plan? 19_

Item IIIE: Is the nursing department's long-range plan prepared similar to the process described in the definition of strategic planning?

Item IIIF: Is the nursing department's long-range plan part of the hospital's long-range plan?
Item IIIG: Which of the following are included in the long-range plan?

- mission statement
- master facilities plan
- financial plan
- capital budget
- marketing plan
- operating budget
- contingency plan
- external environment analysis
- internal environment analysis
- formulating goals/objectives
- formulating priorities
- ranking goals and objectives
- ranking priorities
- formulating strategies to meet goals/objectives
- formulating strategies to meet priorities
- selecting strategies
- implementing strategies
- evaluation

Executive nurse demographic data concerning work history and educational background is contained in items IV, A-D.

Item IVA: How many total years of nursing experience as a registered nurse do you have?

Item IVB: How many years of nursing administration experience at the executive level (Director of Nursing or comparable highest nurse administrator only), do you have?

Item IVC: How many years have you been employed by this hospital in your present position?
**Item IVD:** What is your highest degree?

- ___ associate degree in nursing
- ___ diploma in nursing
- ___ bachelor's in nursing
- ___ bachelor's in another field
- ___ master's in nursing administration
- ___ master's in clinical nursing
- ___ master's in another field
- ___ doctorate in nursing
- ___ doctorate in another field

Nurse executive participation in decisions regarding hospital policy is contained in IV, E.

**Item IVE:** Do you participate in hospital policy decisions such as new services to be provided, facility expansion, or cost containment measures?

The data generated from the above survey instrument were then analyzed using descriptive measures, Analysis of Variance, and Duncan's Multiple Range Test.

**Data Analysis**

Data were analyzed using descriptive measures. First, responses were tabulated for the extent of participation in strategic planning for each size hospital, ownership, and educational level of the executive nurse. Means and standard deviations were obtained.

Second, demographic data for both the hospital and the department of nursing were analyzed regarding: (a) presence
or absence of a plan, (b) whether or not the plan was written, (c) the time period covered by the plan, (d) the year the plan was first generated, (e) whether or not the plan was formulated in a manner similar to the process described in the definition of strategic planning, (f) the planning process, and (g) the plan content. Demographic data regarding the executive nurse included the total years of nursing experience, years of experience as an executive nurse, years employed by the hospital in their present position, their highest degree held, and whether or not they participated in hospital policy decision-making. Means and standard deviations were calculated for the years of nursing experience, years of nursing administration experience, and years in their present position. Demographic data for the hospital included the size and ownership.

Third, mean participation scores for each section of the process of strategic planning and overall mean score for strategic planning were calculated for all hospitals and all departments of nursing.

Fourth, analysis of variance (ANOVA) was performed on the extent of participation in strategic planning by both the institution and the department of nursing in comparison with size, ownership, and educational level to determine whether or not there were significant differences in the
variables of interest. Duncan's Multiple Range Test was also performed to enhance the results of the ANOVA by separating like from unlike variables.
CHAPTER FOUR

Findings

Data Analysis

The purpose of this study was to determine the extent to which Virginia executive nurses participate in strategic planning for their institution, and the extent to which these executive nurses utilize the strategic planning process for their nursing departments. The effect of ownership, size, and educational level of the nurse executive on the extent of participation in strategic planning was also studied.

Characteristics of Surveyed Hospitals

All executive nurses of Virginia short-term nonmilitary hospitals, who are members of the Virginia Hospital Association, were asked to participate in the study. Of the 114 executive nurses, 60 returned the survey, a response rate of 53 percent. The 60 hospitals included: 14 small institutions (< 99 beds), constituting 24 percent of the sample; 35 medium-sized institutions (100-399 beds), constituting 58 percent of the sample; and 11 large institutions (> 400 beds), constituting 18 percent of the sample. There were 48 not-for-profit institutions comprising 80 percent of the sample, and 12 for-profit (investor owned) comprising 20 percent of the sample. These characteristics are displayed in Table 1.
Table 1

Characteristics of Hospitals (N=60)

<table>
<thead>
<tr>
<th>Size of Hospital</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Small (0-99 beds)</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Medium (100-399 beds)</td>
<td>35</td>
<td>58</td>
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<tr>
<td>Large (&gt;400 beds)</td>
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<td>18</td>
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<table>
<thead>
<tr>
<th>Ownership of Hospital</th>
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<td>For-Profit</td>
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The typical executive nurse responding to the questionnaire had between 21 and 25 years of total nursing experience, with one-five years of that time being in nursing administration. The majority of nurse executives managed departments of nursing in medium-size (100-399 beds) not-for-profit institutions. In contrast to Aydelotte's (1984) report about the educational level of nursing administrators in which 60.8 percent held master's degrees, slightly less than half of this sample (47.4%) held a master's degree, either in nursing or in another field. All nurse executives (59), who responded to the questionnaire participated in hospital policy decisions. Table 2 provides further information about the characteristics of the sample.
Table 2
Description of Sample (N=60)

<table>
<thead>
<tr>
<th>Years of Nursing Experience</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>( \bar{X} = 21 ) years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD = 6.56 years</td>
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<td>11-15 years</td>
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<td>&gt;35 years</td>
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<thead>
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<th>Years of Nursing Administration Experience</th>
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<tr>
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<tr>
<td>11-15 years</td>
<td>8</td>
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<td>16-20 years</td>
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<td>Bachelor's in Another Field</td>
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<td>Master's in Nursing Administration</td>
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<tr>
<td>Master's in Clinical Nursing</td>
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<td>Master's in Another Field</td>
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Table 2 continued

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<td>Any BS</td>
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<tr>
<td>Any Master's</td>
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Planning Data

Fifty two, or 87 percent, of hospitals had a long-range plan for the hospital, of which 92 percent were written plans. Thirty-one, or 52 percent, of nursing departments had long-range plans. Eighty-one percent of these plans were written.

Almost all (96%) of the hospitals with long-range plans used the strategic planning process in formulating their plans. Sixty-nine percent of nursing departments with long-range plans used the strategic planning process for formulating their long-range plans.

The majority of the hospitals' long-range plans (62%) covered four years, with three percent initiated before 1965, and 46 percent begun after 1982. Sixty-nine percent of nursing's long-range plans covered three years or less, with four percent initiated before 1965, and 61 percent begun after 1982. Twenty (69%) of the nursing departments' long-range plans were part of the hospitals' long-range plan. Planning data for the hospitals are shown in Table 3, and for the nursing departments in Table 4.
Table 3
Hospital Planning Data

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<td>92</td>
<td>4</td>
<td>8</td>
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<td>49</td>
<td>96</td>
<td>2</td>
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<tr>
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<tr>
<td>&lt;3 years</td>
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<tr>
<td>4 years</td>
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<tr>
<td>5 years</td>
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<td>Year Plan Initiated</td>
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<td>1965-1968</td>
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<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Presence of Plan</td>
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<td>53</td>
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<td>Plan is Written</td>
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<td>81</td>
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<td>19</td>
</tr>
<tr>
<td>Use Strategic Planning Process</td>
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<td>69</td>
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<td>31</td>
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<tr>
<td>Years covered by Plan</td>
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<td>&lt;3 years</td>
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<td>45</td>
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<tr>
<td>3 years</td>
<td>7</td>
<td>24</td>
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<tr>
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<td>5</td>
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<td>After 1985</td>
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<td></td>
</tr>
<tr>
<td>Plan Part of Hospital's Plan</td>
<td>20</td>
<td>69</td>
<td>9</td>
<td>31</td>
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</tbody>
</table>
Elements and Processes Included in Long-Range Plans

Three-fourths of the hospitals included the elements of mission statement (86%), master facilities plan (83%), and marketing plan (76%) in their long-range plans. The majority of nursing departments included the elements of mission statement (87%), capital budget (67%), and operating budget (63%). Additional information is contained in Table 5.

Three-fourths of the hospitals included the processes of analyzing the external environment (81%), analyzing the internal environment (79%), and formulating goals and objectives (77%) in their long-range plans. These processes were closely followed by formulating strategies for goals and objectives (73%), selecting strategies (69%), and implementing strategies (69%).

Three-fourths of nursing departments included the processes of formulating goals and objectives (97%), formulating strategies for goals and objectives (93%), selecting strategies (87%), implementing strategies (87%), formulating priorities (83%), evaluation (80%), and formulating strategies for priorities (77%). Additional information on processes included in long-range planning is contained in Table 5.
Table 5
Elements and Processes Included in Long-Range Plans

<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
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<td><strong>Hospital Elements</strong></td>
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<td>21</td>
<td>70</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Ranking Priorities</td>
<td>20</td>
<td>67</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Formulating Strategies for Goals and Objectives</td>
<td>28</td>
<td>93</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Formulating Strategies for Priorities</td>
<td>23</td>
<td>77</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Selecting Strategies</td>
<td>26</td>
<td>87</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Implementing Strategies</td>
<td>26</td>
<td>87</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Evaluation</td>
<td>24</td>
<td>80</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>
Extent of Participation in Strategic Planning

Mean scores for each segment of the strategic planning process were totalled, and then from the total score a mean score for overall participation in strategic planning was derived. A mean score for each segment of the strategic planning process was also calculated. The possible range of scores for either overall participation or for each process segment was one to five.

The nurse executives' overall mean score for participation in hospital long-range planning was 3.25 (somewhat involved). Except for the nurse executives' participation in external environmental analysis (2.74 = very little involved), there was little difference in the scores for the other segments of the strategic planning process. The mean scores for the remaining strategic planning segments ranged from 3.19 for evaluation to 3.42 for analysis of the internal environment. These results are illustrated in Table 6.

These nurse executives' mean overall participation score for using the strategic planning process for the department of nursing was 4.18 (to a great extent involved). Just as with the scores for participation in hospital strategic planning, except for the nurse executives' involvement in external environmental analysis (3.79 somewhat involved), there was little difference in the mean scores for other segments of the process. Mean scores for utilizing the other
### Table 6

**Extent of Participation in Strategic Planning (N=53)**

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>( \bar{x} )</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Environment Analysis</td>
<td>53</td>
<td>2.74</td>
<td>1.02</td>
</tr>
<tr>
<td>Internal Environment Analysis</td>
<td>53</td>
<td>3.42</td>
<td>0.9</td>
</tr>
<tr>
<td>Establishing Goals/Priorities</td>
<td>53</td>
<td>3.41</td>
<td>0.99</td>
</tr>
<tr>
<td>Strategic Analysis and Choice</td>
<td>53</td>
<td>3.36</td>
<td>1.03</td>
</tr>
<tr>
<td>Implementing Strategic Choice</td>
<td>53</td>
<td>3.39</td>
<td>0.92</td>
</tr>
<tr>
<td>Evaluation</td>
<td>53</td>
<td>3.19</td>
<td>1.07</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>53</td>
<td>3.25</td>
<td>0.86</td>
</tr>
</tbody>
</table>

| **Nursing Department Process**       |    |               |     |
| External Environment Analysis       | 29 | 3.79          | 1.05|
| Internal Environment Analysis       | 29 | 4.38          | 0.56|
| Establishing Goals/Priorities        | 29 | 4.23          | 0.69|
| Strategic Analysis and Choice        | 29 | 4.28          | 0.65|
| Implementing Strategic Choice        | 29 | 4.32          | 0.71|
| Evaluation                          | 29 | 4.05          | 0.86|
| **Total**                           | 29 | 4.18          | 0.66|
strategic planning process segments ranged from 4.05 for evaluation to 4.38 for internal environmental analysis. Details for extent of participation in the strategic planning process for the department of nursing are contained in Table 6.

**Analysis of Variance for Participation in Strategic Planning**

The independent variables of size, ownership, and educational level of the nursing administrator were analyzed with regard to their impact on the extent of participation in the strategic planning process for the hospital and the department of nursing. Analysis of variance (ANOVA) was performed on the mean of the three variables. After the ANOVA was performed, Duncan's Multiple Range Test was also performed. Duncan's Multiple Range Test separated the categories in each variable to isolate significantly dissimilar means from similar means.

ANOVA revealed that size had a significant impact on the extent of participation in hospital strategic planning \((F = 6.74, p < .01)\) with nurse executives in medium-size hospitals being significantly more involved in strategic planning than nurse executives in either small or large institutions. Ownership did not have a significant impact on participation in strategic planning for either the hospital or the department of nursing. The educational level of the
nurse executive was highly significant, with the master's level nurse being more involved in strategic planning for both the institution and the department of nursing. Details of the analysis are contained in Table 7.

Table 7
Results of Analysis of Variance in Strategic Planning by Size, Ownership, and Educational Level (N=60)

<table>
<thead>
<tr>
<th>Variables for Hospital</th>
<th>n</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>53</td>
<td>38.41</td>
<td>4.08</td>
<td>2</td>
<td>6.74</td>
<td>.0026***</td>
</tr>
<tr>
<td>Ownership</td>
<td>53</td>
<td>38.41</td>
<td>0.81</td>
<td>1</td>
<td>1.11</td>
<td>.298</td>
</tr>
<tr>
<td>Education Level</td>
<td>52</td>
<td>38.36</td>
<td>5.21</td>
<td>2</td>
<td>9.14</td>
<td>.0004***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variables for Nursing</th>
<th>n</th>
<th>SS</th>
<th>MS</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>29</td>
<td>1.15</td>
<td>1.15</td>
<td>1</td>
<td>2.82</td>
<td>.1044</td>
</tr>
<tr>
<td>Ownership</td>
<td>29</td>
<td>12.13</td>
<td>0.21</td>
<td>2</td>
<td>0.46</td>
<td>.6370</td>
</tr>
<tr>
<td>Education Level</td>
<td>29</td>
<td>12.14</td>
<td>1.25</td>
<td>2</td>
<td>3.39</td>
<td>.0481*</td>
</tr>
</tbody>
</table>

*P < .05
**P < .01
***P < .001

Duncan's Multiple Range Test groups like means together, thereby isolating significant categories within a variable. Medium size and master's educational level were significant in determining participation in hospital strategic planning. No category was identified as significant for participation in strategic planning for the department of nursing. Details of the Duncan's Multiple Range Test are contained in Table 8.
Table 8
Duncan's Multiple Range Test for Independent Variables

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Mean</th>
<th>n</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>3.566</td>
<td>32</td>
<td>Medium</td>
</tr>
<tr>
<td>B</td>
<td>2.893</td>
<td>9</td>
<td>Large</td>
</tr>
<tr>
<td>B</td>
<td>2.686</td>
<td>12</td>
<td>Small</td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>4.430</td>
<td>5</td>
<td>Small</td>
</tr>
<tr>
<td>A</td>
<td>4.151</td>
<td>19</td>
<td>Medium</td>
</tr>
<tr>
<td>A</td>
<td>4.05</td>
<td>5</td>
<td>Large</td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>3.481</td>
<td>12</td>
<td>For-Profit</td>
</tr>
<tr>
<td>A</td>
<td>3.185</td>
<td>41</td>
<td>Not-For-Profit</td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>4.571</td>
<td>6</td>
<td>For-Profit</td>
</tr>
<tr>
<td>A</td>
<td>4.080</td>
<td>23</td>
<td>Not-For-Profit</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>3.688</td>
<td>25</td>
<td>Any Master's</td>
</tr>
<tr>
<td>B</td>
<td>3.069</td>
<td>12</td>
<td>Any BS</td>
</tr>
<tr>
<td>B</td>
<td>2.659</td>
<td>15</td>
<td>No BS</td>
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<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>4.395</td>
<td>19</td>
<td>Any Master's</td>
</tr>
<tr>
<td>A</td>
<td>3.777</td>
<td>5</td>
<td>No BS</td>
</tr>
<tr>
<td>A</td>
<td>3.775</td>
<td>5</td>
<td>Any BS</td>
</tr>
</tbody>
</table>
Summary

The typical nurse executive in this study held a master's degree, had 21-25 total years of nursing experience of which one-five years was at the executive level, and had been in his/her present position one-five years. Slightly over half of nursing departments had long-range plans covering three years or less. The majority of long-range plans for the department of nursing were formulated by the strategic planning process. Participation in hospital strategic planning was influenced by the institution's size and the nurse executive's education level. Utilization was influenced by neither size nor ownership, only the executive nurse's educational level.
CHAPTER FIVE
Summary and Implications

The purpose of this study was to determine the extent to which hospital nurse executives are participating in strategic planning for the institution, and the extent to which they are using the strategic planning process in their departments of nursing. The effect of hospital size, ownership, and the executive nurse's educational level on both the extent of participation in institutional strategic planning and utilization of the process in nursing departments was also examined.

The following findings of the research are summarized with an emphasis on interpretation and implications for nursing administration. Limitations of the study and suggestions for future research are also included.

Survey Findings

The typical nurse executive in this study held a master's degree, had 21-25 total years of nursing experience of which one-five years was at the executive level, and had been in his/her present position one-five years. Fifty-three percent of nursing departments had long-range plans generally covering three years or less. The majority of plans were written (81%) and formed by the strategic planning process (69%).
Participation in institutional strategic planning was influenced by the hospital's size and the executive nurse's educational level, but not ownership. Nurse executives who generally participated in institutional strategic planning were more likely to be in medium-sized hospitals (100-399 beds) and to hold a master's degree. Utilization of the strategic planning process for the department of nursing was influenced by neither hospital size, nor ownership, but the executive nurse's educational level was significant.

**Interpretation**

**Presence of a Long-Range Plan**

It is not surprising that hospitals in this study had a higher percentage of written long-range plans than did their nursing departments. While federal legislation (Hill-Burton) as early as 1946 has required hospitals to have written plans of one kind or another in order to participate in the federal programs, there are no legislative requirements for planning by departments of nursing. According to Niederbaumer (1979), the nurse's lack of educational preparation in administration is a major barrier to planning by nurse executives. Additional barriers include the failure to solicit nursing input, and a lack of recognition and acknowledgement of the nurse's capacity to fulfill a top management role by hospital administration, physicians, and some nurses (Hagen and Wolf,
The effect of early mandated emphasis on hospital planning is again reflected in the utilization rate of the strategic planning process in formulating long-range plans. While 96 percent of hospital long-range plans were generated by the process of strategic planning, only 69 percent of nursing departments used the process. The lower rate by nursing can probably also be explained by the lack of knowledge and exposure to the process of strategic planning (Fox and Fox, 1983). While the literature abounds with articles on strategic planning for hospitals, few articles are available for nursing on adapting the strategic planning process for their purposes.

**Planning Elements**

There are many elements which can be included as a basis for the hospital or departmental long-range plan. These elements can include: mission statement, master facilities plan, financial plan, capital budget, marketing plan, operating budget, and contingency plan. In this study, nurse executives were requested to identify those specific elements which were in fact included in their own hospital's long-range plan, as well as in the long-range plan for the department of nursing. According to the nurse executives, while most elements included in both the hospital as well as the departmental long-range plans were the same, there were
some differences. For example, although 87 percent of hospitals' and 87 percent of nursing departments' long-range plans included the mission statement, only 43 percent of departmental long-range plans included the master facilities plan, while 83 percent of hospital long-range plans included this same element. There are several reasons which may explain the differences.

One reason is that different elements of the plan may have been more or less critical to the hospitals' or the nursing departments' strategic planning process. For example, 76 percent of the hospitals' long-range plans incorporated a marketing plan, while only 47 percent of the nursing departments included this element. In today's competitive environment more and more hospitals are relying on marketing information in order to increase their share of the health care market. This is reflected in the fact that three out of four hospitals with long-range plans indeed had marketing plans. Yet only 47 percent of departmental plans included marketing plans. Perhaps nursing does not view itself as a revenue generating department and therefore did not place great importance on a marketing plan for nursing.

Another reason is that because of the differing posture and visibility of the nurse executive in the strategic planning process, she/he may not have been completely knowledgeable about the elements included in the hospital's
long-range plan. This cannot be determined since the
questionnaire did not allow for a "do not know" response.

Planning Process

In addition to identifying the elements that were
included in the long-range plans, nurse executives were
requested to designate which of the segments of the strategic
planning processes were included in formulating the long-range
plans. These processes included: analysis of external
environment, analysis of internal environment, formulating
goals and objectives, formulating priorities, ranking goals
and objectives, ranking priorities, formulating strategies
for goals and objectives, formulating strategies for
priorities, selecting strategies, implementing strategies,
and evaluation. Just as the elements included in the plans
were similar, so generally were the process segments used to
formulate the plans also alike.

However, there were also some differences. Of particu-
lar interest was the difference in the use of external and
internal environmental analyses. While nurse executives
identified these processes to a great extent as being used to
formulate the institution's long-range plan (81% and 79%,
respectively), the rate of use was much lower (37% and 50%,
respectively) for these processes in the department of
nursing's long-range plan. The reasons for the differences
in the identified elements and the reasons for the
differences in the identified process segments are not the same.

When reviewing the planning elements contained in both the hospital and departmental long-range plans, the differences could be understood at least in part by the possibility that the nurse executive was not fully aware of the elements included in the hospital's long-range plan. However, this is not true for the differences in the identified process segments. Although the nurse executives identified the process segments of external and internal environmental analyses as being used to a great extent in the hospitals' long-range plan (81% and 79%, respectively), they did not use them when formulating the nursing departments' long-range plan (37% and 50%, respectively). The variance in the scores may reflect the lack of significance the executive nurse places on boundary management for the department of nursing in comparison to the institution. Also, the nurse executives may lack the expertise necessary for applying these segments of the strategic planning process to their nursing departments. In addition to the degree of importance placed by the nurse executives on these particular processes for the department of nursing, the differences in the identified processes may be semantic.

Another interesting finding was the apparent discrepancy between usage rates and extent of participation. For example, only 37 percent of nurse executives reported that
they used "external environmental analysis" when formulating nursing's long-range plan. Yet, when asked the extent to which they participated in activities which are a part of external environmental analysis for the nursing department, the nurse executives had a mean score of 3.79 on a 5.0 scale, indicating a fairly high level of involvement. It is possible that this sample, while in fact quite involved in the activities which constitute strategic planning, were not familiar with the technical language used to describe the process.

**Effect of Education on Participation in Strategic Planning**

Education was a major factor influencing the extent of involvement in hospital strategic planning. Nurse executives who held a master's degree were more involved in strategic planning than either nurses with bachelor's degrees or diplomas. One of the reasons for this difference may be that curricula of diploma, associate degree, and bachelor's degree programs generally concentrate on the planning of individual patient care and unit management, not strategic planning. Therefore, nurses in these programs have not been exposed to the process of strategic planning. This lack of formal exposure to strategic planning, combined with minimal information on strategic planning available in the nursing literature, has resulted in nurse executives without master's degrees
being unable to participate in strategic planning for either the institution or the department of nursing.

In addition, the credentials of the nurse executives with a master's degree may gain them recognition by hospital administration as being capable of participating in strategic planning. Therefore, the nurse executives become part of the group responsible for strategic planning, because they have educational levels comparable with other hospital executives.

**Effect of Size on Participation in Strategic Planning**

Hospital size influenced the extent of nurse executive participation in hospital strategic planning. Size did not influence the extent of utilization of the strategic planning process for the department of nursing. Nurse executives who worked in medium-sized hospitals (100-399 beds) were more likely to participate in institutional strategic planning than those who worked in small or large institutions.

Greater participation in strategic planning in medium-sized hospitals may be due to the higher number of nurse executives with master's degrees in medium-sized hospitals (57%) than in small hospitals (21%). Although 55 percent of nurse executives in large institutions held master's degrees, large institutions were not identified as a significant variable for participating in strategic planning. Perlin
(1972) found that three-fourths of long-range planning was done by the chief executive officer, and Pitts (1984) discovered that in Virginia plans were done internally and approved by the board of trustees. Therefore, while nurse executives in large institutions may have been educationally prepared to participate in strategic planning, they may not have been included as a member of the group responsible for formulating, finalizing and approving the institution's long-range plan.

**Effect of Ownership on Strategic Planning**

Hospital ownership affected neither participation in hospital strategic planning nor utilization of the strategic planning process for the department of nursing. Perhaps ownership is not a significant variable because it is not the only factor in determining either where or by whom strategic planning will be accomplished.

**Summary**

In this study, ownership influenced neither participation in strategic planning for the hospital nor utilization of the strategic planning process for the department of nursing. Hospital size did effect the extent of nurse executives' participation in hospital strategic planning. The nurse executive's educational level significantly influenced both his/her participation in institutional
strategic planning and the utilization of the strategic planning process for the department of nursing. Therefore, when nurse executives have both the necessary knowledge and the opportunity to participate in hospital strategic planning, they will do so. Since nurse executives are responsible for their own departmental planning, nurse executives are restrained in the use of strategic planning for the department of nursing only by their lack of knowledge in the strategic planning process.

Implications

The current turbulent environment in which hospitals and nursing departments conduct their business has resulted in a search for methods which will enable hospitals and departments of nursing to prosper. Hospitals as human organizations are dynamic open systems whose boundaries are relatively elastic and permeable rather than fixed. One method which enhances the chances of prospering, through facilitating the matching of organizational strengths with environmental opportunities, is planning.

Over the years, planning in hospitals has evolved and taken many forms: management by objectives, capital budgeting, long-range planning, and currently strategic planning. Strategic planning is a method utilized to manage the boundary between the hospital and its external environment. Bourgeois (1980) stated:
One can find among the many definitions that strategy has two primary purposes of defining the segment of the environment in which the organization will operate and providing guidance for subsequent goal-directed activity within that niche (p. 27)

The process of strategic planning involves: assessing the external and internal environments, establishing goals based on this assessment, formulating strategies to achieve prioritized goals, selecting the strategy(ies) to be implemented, implementing the strategy(ies), and evaluating the success of the implementation and outcome of the strategic planning process.

Traditionally, both operational and strategic planning have been accomplished by the board of trustees and the hospital's chief executive officer without participation by the director of nursing service. In 1982, the American Society for Nursing Service Administrators' follow-up survey of its 1977 study revealed that the role of nurse executives had evolved to include increased participation in institutional governance and fiscal management. There were also significant changes in reporting relationships. Although nurses are participating in operational planning for both the institution and their departments (Stuart, 1985), no information regarding the extent of participation by the nurse executive in the strategic planning process for the hospital or utilization of the process by nurse executives for managing their departments of nursing can be found in the literature.
While hospitals use strategic planning to a great extent for managing the boundary between the institution and the external environment to enhance their chances of survival, executive nurses are not as actively involved in strategic planning. The reasons that many executive nurses continue to be not as actively involved in departmental planning may be as cited by Fox and Fox (1983), a lack of knowledge or experience for implementing formal planning, and the heavy demands for immediate resolution of daily crises.

In this study, executive nurses were more likely to be involved in strategic planning if they had a master's degree and/or were employed in a medium-size hospital. More education increases involvement in strategic planning because generally curriculums at lower educational levels do not include information on strategic planning. Nurse executives may not be as involved in strategic planning in large hospitals because strategic planning may be being accomplished by the chief executive officer and the board of trustees. However, nurse executives may influence strategic planning through their participation in other policy decision arenas and interactions with members of the group responsible for strategic planning. Involvement in strategic planning for smaller institutions may be limited because planning is accomplished by the chief executive officer and the board of trustees and/or the nurse executive at smaller hospitals.
tended to have less education (22 percent had master's degrees) than those at medium (56 percent with master's degrees) and large institutions (56 percent with master's degrees).

The failure of the nurse executive to participate in strategic planning is a disservice to the institution as well as to the department of nursing, because contributions which could be made by the nurse executive are never solicited. Nurse executives can participate in all phases of the strategic planning process. For example, by contributing information gleaned via already established external channels of communication with the public through interactions with patients, their families, and other community members (Lukacs, 1984), nurses can participate in the assessment of strategic planning. Stuart (1985) stated that based on studies by Schultz (1972), Shortell, Becker and Neuhauser (1967), and Shortell and LoGerfo (1981):

one might expect that increased participation by nursing would be associated with positive outcomes for hospital effectiveness and viability through increasing the organization's command of its internal environment and resources (p. 53).

Implications for Nursing Practice

Nurse executives, if they are to achieve greater autonomy for the practice of nursing, must continue to increase their involvement in strategic planning for both the department of nursing and their institutions, and to set a
higher value on planning than has traditionally been placed (Fox and Fox, 1983). Autonomy can only occur if executive nurses have the knowledge and opportunity to support nursing. Manson (1983) stated that the nurse executive of the future must possess financial management skills, computer knowledge, marketing and public relation skills, and the ability to analyze data and formulate short and long-range plans based on economic and clinical information. Niederbaumer (1979) asserted that nursing participation in policy level decision-making was the only effective manner to plan, integrate and implement the hospital's goals.

All nurse executives in this study were part of the decision-making process; and they must also become part of the planning process in order to advance nursing practice as well as improve organizational effectiveness through aligning nursing's priorities, goals, and objectives with the institution's, and through influencing the institution's priorities, goals, and objectives. Only through management of the boundary between the department of nursing, the institution and the external environment can executive nurses enhance effectiveness for both their departments and their institutions. Strategic planning promotes the managerial flexibility necessary to respond proactively to new information, thereby increasing long-term viability of organizational contributions and programs (Camillius, 1980). Pfeffer and Salancik (1978) wrote that external environments
must be effectively managed if organizations are to survive. Increased involvement in strategic planning will occur only with increased education of the executive nurse and the opportunity to participate in strategic planning. Niederbaumer (1979) stated that in many institutions the director of nursing was unknown to the trustees and others in policy-making positions.

This study has shown a relationship between education and participation in strategic planning for both the institution and the department of nursing. Executive nurses are involved in strategic planning if they have the knowledge to do so. Nurse administrators must be prepared at the master's level if they are to effectively participate in institutional strategic planning. When nurse executives are capable of participating in strategic planning they are most likely not only to be included in institutional strategic planning, but will utilize the strategic planning process for their nursing department.

Limitations

Limitations of the study include both technical and practical aspects. A specific design weakness of this study is that the instrument may not reflect that institutional planning is being done if planning is done external to the organization or by another process, i.e., participants would respond "no" to questions regarding presence of a plan,
and/or may not be aware that a long-range plan exists because it is generated by individuals who are not part of the daily management of the hospital. Responses to questions (IH) and (IF) on the questionnaire, which delineated the process of planning, provided insight as to how the plan was formulated, but not necessarily where the planning function was performed, i.e., done within the institution or external to the institution.

Another problem with the questionnaire was the technical language used to designate the strategic planning processes. This was identified by the discrepancy between the low rates of the strategic planning processes identified by the executive nurses as being used in formulating the long-range plans, and the nurse executives' relatively high mean scores for participating in the strategic planning processes. Attempts to pilot the questionnaire outside Virginia were not successful, and the researcher did not want to decrease the sample by using executive nurses from Virginia.

Practical weaknesses include that the study was only done in Virginia and included only those nonmilitary hospitals belonging to the Virginia Hospital Association. The sample was not random, there was a low response rate (53%), and reliability and validity of the tool were not determined. Another concern was the questions which were not asked and which might have provided additional insight. Such questions as: "Was the nurse executive a member of the group
responsible for formation and/or approval of the strategic plan" would have been helpful in analyzing the data. The data were not analyzed to determine the interrelationship among the executive nurses' educational level, the size of facility in which they were employed, and participation in strategic planning.

There are no norms for who should participate in which types of planning. The studies involving planning have generally focused on the presence or absence of planning and who is involved in the process, but no study has been conducted to identify the effect on the outcome of planning by the presence or absence of a particular individual. It is not known from this study who were the individuals responsible for strategic planning at each institution; the nurse executive may not have been the only member of the hospital executive team not participating in strategic planning.

**Recommendations for Future Research**

There are many difficulties in descriptive surveys when studying new areas such as strategic planning. The relationship between strategic planning and outcome effectiveness has not been clearly established for the hospital (Pitts, 1984), and no studies have been conducted involving strategic planning effectiveness for the department of nursing.

While replication of this study with a larger sample size would also be of interest, additional future questions
which could be studied include:

1. Are nursing departments with long-range plans more efficient and effective than those nursing departments without long-range plans?

2. Are departments of nursing with long-range plans generated by the strategic planning process more efficient and effective than nursing departments with long-range plans formulated by other planning processes?

3. Which elements included in long-range strategic plans result in the best outcomes?

4. Who or what level of personnel should be involved in nursing long-range strategic planning for the best outcome?

5. What levels of nursing personnel should be involved in which segments of the strategic planning process?

6. All of the above questions could be asked of non-hospital based nursing departments, as well as comparing and contrasting hospital based nursing departments with non-hospital based nursing departments.

A related set of questions regarding why having a master's degree is significant for participation in strategic planning include:

1. Are executive nurses with master's degrees more assertive than executive nurses without a master's degree?
2. Do executive nurses with master's degrees have a more positive self-concept than executive nurses without a master's degree?

Conclusion

The purpose of this study was to determine the extent to which hospital nurse executives are participating in strategic planning for the institution, and the extent to which they are using the strategic planning process in their departments of nursing. Additionally studied was the effect of hospital size, ownership, and the executive nurses' educational level on both the extent of their participation in institutional strategic planning and their utilization of the process in their nursing departments. This chapter has summarized the findings of a survey questionnaire mailed to nonmilitary hospital based Virginia executive nurses. Interpretation of these findings was made and implications for nursing administration were discussed. The limitations of this study and recommendations for future studies were suggested.
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BIBLIOGRAPHY


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APPENDIX A

COVER LETTER AND SURVEY QUESTIONS
Dear Colleague:

I am a graduate student in nursing administration at Medical College of Virginia/Virginia Commonwealth University. To fulfill the thesis requirement, I am conducting a study of the executive nurse's participation in the strategic planning process. The study includes all acute care hospitals in Virginia. Executive nurses in these hospitals are being asked to participate in the survey. Your participation in this study would be greatly appreciated.

Participation in this study is entirely voluntary. Your responses will be reviewed only by me and will be accessible to no others. Although responses will be coded to allow for questionnaire follow-up, procedures have been developed to protect your privacy and the confidentiality of the data. Neither your name nor your institution's name will appear on any data forms and will not be used in any report of the findings. All data will be reported as aggregate statistics only, so that no individual or institution will be recognizable in any results reported. The completion of this questionnaire and the return of it to me signifies your consent to participate in this study. You may withdraw at any time by notifying me of your wish to do so.

If you have any questions, please contact me at [Contact Information]. A copy of the study results will be provided to you if you so desire. Thank you for your support and participation.

Sincerely,

Mary R. Pippin, R.N., B.S.N.
SURVEY QUESTIONS

I. Hospital Information

A. Your hospital is:
   - 0-99 beds
   - 100-399 beds
   - 400 beds or more

B. Your hospital is classified as:
   - nonprofit
   - for profit

Definition of Strategic Planning

Strategic planning is a process whereby a plan is prepared by analyzing elements in both the external and internal environment, deriving goals based on the analysis, formulating and then selecting a strategy(s) to meet the goals, implementing the strategy, and finally evaluating the success of the plan. For example, the analysis of your external environment may reveal a population of young married couples and no obstetrical care being provided by other local hospitals. The internal analysis of the medical staff and your facility reveals one physician, age 66, who is providing obstetrical care and an outdated and under-utilized obstetrical unit. Based on the analysis the hospital formulated a goal of providing obstetrical care for the community. Strategies included recruiting two young obstetricians, modernizing the obstetrical unit, and media promotion. Time frames were established for implementing the strategies and the plan was frequently evaluated and revised as necessary based on new elements in the external or internal environment.

C. Does your hospital have a long-range plan?
   - Yes
   - No

If your answer is "no," please go to Section III Planning Process for the Department of Nursing on page 5.

D. If your hospital has a long-range plan, is it written?
   - Yes
   - No

E. What is the time period covered by the long-range plan?
   - less than 3 years
   - 3 years
   - 4 years
   - 5 years
   - greater than 5 years
F. Which of the following are included in the long-range plan?

- mission statement
- master facilities plan
- financial plan
- capital budget
- marketing plan
- operating budget
- contingency plan
- external environment analysis
- internal environment analysis
- formulating goals/objectives
- formulating priorities
- ranking goals and objectives
- ranking priorities
- formulating strategies to meet goals and objectives
- formulating strategies to meet priorities
- selecting strategies
- implementing strategies
- evaluation

G. In what year did your hospital first prepare a long-range plan? 19__

H. If your hospital has a long-range plan, is it formulated similar to the process described in the definition of strategic planning process?

- Yes
- No

For the next section of the questionnaire, using the below scale, please answer the questions by placing the number which corresponds to your response in the space provided. Because little is known about who actually participates in strategic planning, there are no "incorrect" or "correct" responses.

1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent

II. Planning Process for the Hospital

Section A:

- 1. To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national economic environment which could influence the way business is conducted, or the services which are offered? For example: information might relate to new insurance coverage, reimbursement rates for third party payors or the opening/closing of a community industry.
(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

____ 2. To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national political environment which could influence the way business is conducted, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or a local competitor's plans for a new service or facility.

____ 3. To what extent do you participate in gathering and analyzing information regarding changes in health care and/or information management system technology which could influence the way business is conducted or the services which are offered? For example: installation of an automated patient care information system, or the need for home health care services.

____ 4. To what extent do you participate in gathering and analyzing information concerning local, state, and/or federal social policy which could influence the way business is conducted or services are offered? For example: minority needs, community activities, or consumer profiles.

Section B:

____ 1. To what extent do you participate in gathering and analyzing information regarding the hospital's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel?

____ 2. To what extent do you participate in gathering and analyzing information regarding the financial status? For example: hospital's income and balance sheets, financial ratio analysis, or cost containment measures.

____ 3. To what extent do you participate in gathering and analyzing information regarding productivity? For example: variance analysis.

____ 4. To what extent do you participate in gathering and analyzing information regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.
(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

5. To what extent do you participate in gathering and analyzing information regarding the hospital's current health care delivery, or its existing information management system's technology? For example: new products/procedures, or additions to or replacement of the current information management system.

6. To what extent do you participate in reviewing and revising the hospital's mission statement?

Section C:

1. To what extent do you participate in formulating goals/objectives based on the hospital's internal environmental analysis?

2. To what extent do you participate in formulating goals/objectives based on the hospital's external environmental analysis?

3. To what extent do you participate in ranking the goals/objectives?

4. To what extent do you participate in formulating priorities based on the hospital's internal environmental analysis?

5. To what extent do you participate in formulating priorities based on the hospital's external environmental analysis?

6. To what extent do you participate in ranking the priorities.

Section D:

1. To what extent do you participate in formulating possible strategies for the hospital's long-range plan?

2. To what extent do you participate in analyzing the costs/benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/objectives/priorities?

3. To what extent do you participate in evaluating the advantages and/or disadvantages of proposed strategies relevant to the resources, competence and preferences of the organization?

4. To what extent do you participate in selecting from the proposed strategies the strategic choice(s) which will be implemented?
(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

Section E:

1. To what extent do you participate in developing policies for implementing the strategic choice(s)?
2. To what extent do you participate in developing plans for implementing the strategic choice(s)?
3. To what extent do you participate in identifying individuals who will be responsible for implementing the strategic choice?
4. To what extent do you participate in selecting individuals who will be responsible for implementing the strategic choice?

Section F:

1. To what extent do you participate in developing performance measures for monitoring and controlling implementation of the strategic choice(s)?
2. To what extent do you participate in analyzing the performance measures' results?
3. To what extent do you participate in evaluating the success of implementing the strategic choice(s)?
4. To what extent do you participate in re-evaluation of current goals/objectives, priorities and strategies in light of new elements in the external or internal environments, or a change in the mission?

III. Planning Process for the Department of Nursing

A. Does the department of nursing have a long-range plan?

Yes No

If neither the hospital nor the department of nursing has a long-range plan, do not continue with the questionnaire, but please return this questionnaire by mail. Thank you for your participation. If your answer is "yes," please continue with the questionnaire.

B. Is the department of nursing's long-range plan written?

Yes No
C. What is the time period covered by the long-range plan?
   _____ less than 3 years
   _____ 3 years
   _____ 4 years
   _____ 5 years
   _____ greater than 5 years

D. In what year did the department of nursing first prepare a long-range plan? 19

E. Is the nursing department's long-range plan prepared similar to the process described in the definition of strategic planning?
   _____ Yes   _____ No

F. Is the department of nursing's plan part of the hospital's long-range plan?
   _____ Yes   _____ No

G. Which of the following are included in the long-range plan?
   _____ mission statement
   _____ master facilities plan
   _____ financial plan
   _____ capital budget
   _____ marketing plan
   _____ operating budget
   _____ contingency plan
   _____ external environmental analysis
   _____ internal environmental analysis
   _____ formulating goals/objectives
   _____ formulating priorities
   _____ ranking goals and objectives
   _____ ranking priorities
   _____ formulating strategies to meet goals and objectives
   _____ formulating strategies to meet priorities
   _____ selecting strategies
   _____ implementing strategies
   _____ evaluation
Please answer the following questions using the below scale. Because little is known about who actually participates in strategic planning, there are no "correct" or "incorrect" responses.

1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent.

Section A:

_____ 1. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national economic environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: information might relate to new services or procedures which the hospital or department of nursing could offer, direct reimbursement for nursing services, or separation of nursing service charges from hospital bed and board charges.

_____ 2. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national political environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or changes in the nurse practice act.

_____ 3. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding changes in health care and/or information management system technology which could influence the way the department of nursing conducts its business or the services which are offered? For example: improvement of automated nurse staffing and scheduling systems, or the need for home health services.

_____ 4. When preparing nursing's long-range plan, to what extent do you gather and analyze information concerning local, state, and/or national social policy which could influence the way the department of nursing conducts its business or services which are offered? For example: minority needs, community activities, or consumer profiles.
Section B:

1. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the department of nursing's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel?

2. When preparing nursing's long-range plan, to what extent do you gather and analyze information for the department of nursing regarding its financial status? For example: variance analysis, number of patient care hours needed per patient classification category, or skill mix.

3. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding productivity for the department of nursing? For example: variance analysis.

4. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.

5. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the nursing department's current health care delivery, or its existing information management system's technology? For example: new products/procedures, or additions to or replacement of the current information management system.

6. When preparing nursing's long-range plan, to what extent do you review and revise nursing's mission statement?

Section C:

1. When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's internal environmental analysis?

2. When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's external environmental analysis?

3. When preparing nursing's long-range plan, to what extent do you rank the goals/objectives for the department of nursing?
(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

4. When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's internal environmental analysis?

5. When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's external environmental analysis?

6. When preparing nursing's long-range plan, to what extent do you rank priorities.

Section D:

1. To what extent do you formulate possible strategies for nursing's long-range plan?

2. To what extent do you analyze the costs/benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/objectives, and priorities?

3. When preparing nursing's long-range plan, to what extent do you evaluate the advantages and/or disadvantages of the proposed strategies relevant to the resources, competence, and preferences of the organization?

4. When preparing nursing's long-range plan, to what extent do you select from the proposed strategies the strategic choice(s) which will be implemented?

Section E:

1. When preparing nursing's long-range plan, to what extent do you develop policies for implementing the strategic choice(s)?

2. When preparing nursing's long-range plan, to what extent do you develop plans for implementing the strategic choice(s)?

3. When preparing nursing's long-range plan, to what extent do you identify individuals who will be responsible for implementing the strategic choice?

4. When preparing nursing's long-range plan, to what extent do you select individuals who will be responsible for implementing the strategic choice?
(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

Section F:

1. When preparing nursing's long-range plan, to what extent do you develop performance measures for monitoring and controlling implementation of the strategic choice(s)?

2. When preparing nursing's long-range plan, to what extent do you analyze the performance measures' results?

3. When preparing nursing's long-range plan, to what extent do you evaluate the success of implementing the strategic choice(s)?

4. When preparing nursing's long-range plan, to what extent do you re-evaluate current goals/objectives, priorities, and strategies in light of new elements in the external and internal environments, or a change in the mission?

Please answer the following demographic questions:

IV. Executive Nurse Information

A. How many total years of nursing experience as a registered nurse do you have? _____

B. How many years of nursing administration experience at the executive level (Director of Nursing or comparable highest nurse administrator only), do you have?
   _____ (years) _____ (months)

C. How many years have you been employed by this hospital in your present position?
   _____ (years) _____ (months)

D. What is your highest degree?
   _____ associate degree in nursing
   _____ diploma in nursing
   _____ bachelor's in nursing
   _____ bachelor's in another field
   _____ master's in nursing administration
   _____ master's in clinical nursing
   _____ master's in another field
   _____ doctorate in nursing
   _____ doctorate in another field
E. Do you participate in hospital policy decisions such as new services to be provided, facility expansion, or cost containment measures?

_____ Yes  _____ No

Thank you for your participation.

Please indicate whether or not you would like a copy of the results of this study.

_____ Yes  _____ No
VITA