

A Strategic Planning Process for a Small Nonprofit Organization A Hospice Example

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Strategic planning is an essential part of management. However, planning processes can consume great amounts of time and resources that small, nonprofit organizations may lack. Moreover, the process that is used can be tedious and may result in plans that are discarded before or during their implementation. In this article, a strategic planning process is presented that incorporates a Policy Delphi group technique and Situation Structuring, a computer program that assists participants in structuring or defining the problems to be addressed in the plan. The organization to which the process is applied is a small, nonprofit hospice. Both the planning process and an evaluation of the implementation of the resultant strategic plan are examined.

STRATEGIC planning has become an important element in the management of for-profit and nonprofit organizations. Although strategic planning processes may result in lengthy, often-ignored sets of plans, this result is not a necessary outcome. Strategic planning is, simply, “a systems approach to maneuvering an enterprise over time through the uncertain waters of its changing environment to achieve prescribed aims” (Steiner, 1979, p. 16).

Strategic planning is not new. Almost three decades ago, Ackoff (1970) wrote about corporate planning. Below, Morrissey, and Acomb (1987) added to the literature. Bryson (1995) focused attention on the nonprofit sector. Mintzberg (1994) found fault with planning processes that had limited effect. More recently, Mulhare (1999) questioned the usefulness of strategic planning in nonprofit organizations. A process that is not burdensome, however, can facilitate the planning endeavor as well as implementation of the resultant plan.

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One function of strategic planning is to assist in allocating scarce resources in an environment of competing demands. A second function is to strengthen an organization's financial viability (Goldsmith, 1994). Both of these endeavors occupy much of the nonprofit leader's time and energy. However, nonprofit organizations, especially small ones, do not have unlimited resources to allocate to planning. They need a process that is "doable" as well as one that is interesting.

In this article, such a process is described. It incorporates two techniques, Policy Delphi and Situation Structuring. Policy Delphi is a group technique that calls on the knowledge of the participants while affording them anonymity as their input is shared by the facilitator. In this way, ideas are evaluated on their own merit rather than on the power or influence of the person offering the idea. Situation Structuring is a computer program that facilitates the "structuring" or defining of a problem. Too often, problem definition is omitted from a planning process. If the structuring of a problem is not a beginning step in a planning process, participants may spend a great deal of time addressing issues that are not core problems.

The case to which the strategic planning process is applied is that of a small, nonprofit hospice. Hospice care is provided to people with a life expectancy of six months or less and also to their families. Care is provided through an interdisciplinary group (IDG) consisting of one or more physicians, nurses, social workers, nursing aides, specially trained volunteers, clergy (if desired by the client), and other health care professionals as needed. The individual facing death and the family also are part of the team. The focus is on alleviation of symptoms, helping the individual to be as comfortable and pain free as possible.

Background

In 1990 I developed and carried out a strategic planning process at New River Valley (NRV) Hospice in Blacksburg, Virginia, which at that time lacked a strategic plan. The hospice serves the residents of four political jurisdictions in southwestern Virginia. From the start of the hospice in the early 1980s, care was provided without cost to patients and their families. The organization relied on various funding sources, including five United Way organizations, grants, an annual campaign consisting of fundraising letters, and the sale of coupons from a fast-food restaurant chain for which the hospice received a percentage of the profits. The organization depended heavily on volunteer physicians, nurses, social workers, lawyers, and clergy.

Certain factors contributed to the need to change funding measures. One was state hospice licensure, which would necessitate the employment of additional paid staff members. At the same time, the organization's income was becoming less predictable due to the increasing uncertainty of donations to the United Way, the primary

hospice funders. As a result of these factors, the hospice benefit added to Medicare in 1983 became more attractive to NRV Hospice. However, Medicare certification, like state licensure, would necessitate the hiring of additional paid staff. Certification, unlike licensure, would be accompanied by reimbursement for care. Licensure was mandatory; certification was optional. There was no consensus regarding the direction NRV Hospice should take.

Strategic Planning Process

Within this context, NRV Hospice needed a sense of direction, which was provided through the development of a strategic plan. The combined use of two policy analysis techniques formed a structured planning method with three steps:

1. A group meeting, using a modified Policy Delphi technique, in which a list was developed of elements (or characteristics) of the hospice that were considered the most important and most certain to be realized in the next five to ten years
2. An individual meeting with each participant, using Situation Structuring computer software, during which “word pictures” of the strategic plan were developed (word pictures, also known as problem structures, consist of words and phrases arranged on a page in such a way as to convey a strategic plan with a minimum of words)
3. A group meeting in which a combined picture of the strategic plan was developed

The original Delphi technique, developed at Rand Corporation in 1948, addressed forecasting needs related to military strategy. The technique was designed to avoid a number of sources of dysfunctional group communication, including interpersonal conflicts among group members, peer pressure, dominating behavior by one or more group members, and the problems associated with opposing others in public, especially people in authoritative positions (Dunn, 1994). Technical topics formed the focus of early applications of Delphi. Policy Delphi, introduced in 1970 (Turoff, 1970), is an innovation to the basic technique that focuses on generation of “the strongest possible opposing views on the potential resolution of a major policy issue. . . . A policy issue is one for which there are no experts, only informed advocates and referees” (Buck, Gross, Hakim, and Weinblatt, 1993, p. 274).

Policy Delphi fosters objectivity by using selective anonymity, whereby participants’ input remains anonymous in the first stages of the process, when the various contending alternatives are surfaced. In an iterative fashion, participants’ input is presented to all participants in an aggregated form. Instead of focusing on the participation of experts (as in the original technique), informed multiple advocacy

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focuses on obtaining input based on the interest and knowledge of “a representative group of informed advocates” (Dunn, 1994, p. 197). The statistical measures used in Policy Delphi to summarize individual input intentionally focus on conflict and disagreement. The principle of structured conflict is based on the assumption that disagreement is to be expected in policy discussions. Conflict is used to examine alternatives and their consequences in a creative fashion, surfacing the assumptions underlying the various positions.

At NRV Hospice, a modified Policy Delphi technique was used to formulate a list of projected elements or characteristics of the hospice in five to ten years. People who were key in the hospice organization generated the list. These elements were used in the second step of the planning process, the two-part meeting with each participant. Situation (Problem) Structuring, a computer software program designed by John Dickey, was used in the first part of the meeting.¹ The program provides a problem structuring method based on the Kelly Repertory Grid (Kelly, 1955). The grid consists of columns containing the potential elements or characteristics of the hospice and rows containing constructs or dichotomies developed by each participant. The information in the grid is used to assist the participant in clustering the elements or characteristics into meaningful groupings. These groupings are used in the next part of the process.

The second part of the individual meetings consisted of non-computer work and built on the Situation Structuring results. This part of the process resulted in individual formulations, or word pictures, of the solutions to the problems developed by each participant.

In the third step, participants met as a group to devise a group picture of the hospice’s strategic plan. The process followed in this endeavor was adapted from the work of Morcol (1990). The development of a strategic plan had the support of the board of directors, to whom the plan was submitted for approval.

Policy Delphi

Identifying the elements of the problem is an important one. The acceptance of new elements into a person’s thinking can serve as a catalyst for the formation of new associations among elements. These associations can facilitate the formation of new constructs or different combinations of previously held constructs (Kelly, 1955). This process allows the participant to see the problem in new ways, facilitating the use of creative thinking.

The elements generated in this process determine the universe of discourse (Shaw and Gaines, 1986). Creativity can be fostered by generating the list of elements in a group setting. An element suggested by one participant may spark ideas for new elements in other participants (Morcol, 1990). Four key hospice individuals met for this project: an administrator and nurse, a social worker, an administrator and volunteer coordinator, and a member of the board of

directors. In retrospect, a family member of a hospice patient could have been included. Two of the individuals on the planning team, however, had been provided assistance by a hospice in the care of friends who were facing death. I served as the process facilitator, and because I was employed at that time by the hospice, no consultant costs were incurred.

Policy Delphi was chosen for a number of reasons. Either a nominal or an interactive group process can be used to elicit elements of a problem in a group setting. In an interactive process, participants react as ideas are introduced; in a nominal process, participants provide information anonymously and without discussion. The nominal group technique, which includes Policy Delphi, is more time-consuming than is an interactive process. However, nominal groups are thought to be more effective in facilitating participation by preventing the group from being dominated by a few members. Nominal group techniques also foster creativity by working against a move toward participant conformity (Delbecq and Van de Ven, 1971).

The purpose of the Delphi meeting, which lasted approximately two hours, was to elicit desired elements or characteristics of NRV Hospice in the future. Participants were asked to write, from their point of view, the most promising elements of the hospice in the next five to ten years. The facilitator listed each of the elements, and then participants identified and eliminated duplications. The final list contained the following elements:

- In-patient facility
- Medicare certification
- State licensure
- Current staff working at full-time rather than part-time level
- A full complement of staff (to include those positions required by Medicare)
- Broad-based funding
- Comprehensive care in all areas
- Competitive salaries
- Permanent office with disabled access

In the Delphi procedure, each participant was asked to rank the importance and the certainty of each element and then individually and anonymously assign values to each of the elements, along with their reasons for assigning those values. The facilitator then shared the list of numbers and reasons with the group. After hearing this list, participants were asked to rate the elements again. In a second rating, participants can be influenced by the ratings and the related reasons from the first rating. In this way, a group list of elements was developed. An additional advantage of ranking the importance and certainty of each element is evident when participants generate a lengthy list of elements, which can be a hindrance later in the process

when Situation Structuring is used (Morcol, 1990). Therefore, only elements that the participants agree are more important and more certain of happening are included in the final list.

Each participant was asked to rate the importance of each element on a seven-point scale, with 1 being “unimportant” and 7 being “very important,” and was asked to write his or her reasons for assigning each number. The importance level assigned to each element by the participants ranged from 3 to 7.

After the reasons for assigning the importance values were shared with the group, it became apparent that one of the elements, comprehensive care in all areas, contained two elements. The participants agreed to separate the two, resulting in “NRV Hospice will provide comprehensive care” and “NRV Hospice will provide care in all areas of the NRV Planning District.”

The facilitator asked each participant to rate again the importance of the elements for which there was not agreement in the first rating process. These numbers were shared with the group. The separation of “comprehensive care in all areas” into two elements had helped to clarify the participants’ ideas regarding the importance of these elements. Otherwise little change occurred in the ratings. This lack of variance may have been due to the high level of agreement in the first recording.

Next, each participant was asked to rate his or her level of certainty that each of the elements would be a part of the hospice in the next five to ten years. A seven-point scale was used, with 1 being “very uncertain” and 7 being “very certain.” Participants also were asked to write their reasons for their responses. A second round resulted in the same ratings.

The elements that received an average value of 5 or more on both the importance and certainty ratings were selected for use in the next step, Situation Structuring. There was a high level of group agreement for these elements: Medicare certification, state licensure, current staff at full-time level, a full complement of staff, broad-based funding, comprehensive patient care, expanded service area, and competitive salaries.

Situation Structuring

In the next step, Situation Structuring, a computerized adaptation of the Kelly Repertory Grid was used. The grid provides a method of problem structuring, an initial step in a planning process, and can yield solutions that might not be evident otherwise. The facilitator met individually with each participant for approximately an hour. The participants in this part of the process were the same as in the Delphi procedure, with one exception. One board member who expressed fear of computers and did not wish to participate was replaced by a former board member who currently served as volunteer coordinator, home care volunteer, and personnel consultant.

In beginning the process, the facilitator typed the nine elements identified in the Delphi procedure into the computer program. The participant reviewed these elements and was asked if she or he would like to add, delete, or modify any of them. After the facilitator entered any changes the participant requested, the computer program iteratively selected three of the elements at random. The process that followed is called triangulation or triad elicitation (Kelly, 1955). The participant was asked in what way two of the elements were alike and in what way the remaining one was different. For instance, if the three elements were “Medicare certification,” “state licensure,” and “full complement of staff,” the participant might think that the first two were alike because they were regulations and that they differed from the third element, which related to staffing. The resulting construct would be “regulations—staffing.” In this way, the following constructs or dichotomies were developed:

- Provision of care—resources to provide care
- Necessary—optional
- Improved patient care—increased number of patients
- Number of staff hours—number of counties/cities served
- Government regulations—local discretion
- Requires funding—provides funding
- Staffing—funding

In the next step, each of the elements was rated on each of the constructs. The columns of the grid were composed of elements, and the rows of the grid were composed of constructs. (The grid shape itself is not shown in the computer program.) In this step, the participant was asked to rate an element, perhaps “state licensure,” on a construct, say, “regulations—staffing,” on a scale from 1 to 5. If the element was more like the left side of the scale, “regulations,” it was assigned a 1. If it was more like the right side of the scale, “staffing,” it was assigned a 5. In the example, state licensure was composed of regulations and therefore could be assigned a 5. If the element was equally related or equally unrelated to both sides, it was assigned a 3. Fractions can also be used. These ratings allow for the clustering of elements (by the computer program) into progressively smaller numbers of groupings. Within these groupings are similar elements. This clustering continued until all of the elements were in the same group. The numbers of stages varied among participants.

The participant then gave a name to each grouping of elements. The name represented the way in which the participant saw the elements as similar. For instance, a grouping of the elements “current staff at full-time level,” “full complement of staff,” and “competitive salaries” might be named “staffing needs.”

The computer program then provided a G-value for each grouping. The greater the homogeneity was of the elements in a particular grouping, the higher was the G-value. G-values ranged from 1

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(each element was in its own group) to almost 0 (all elements were in the same group and had virtually no homogeneity).

The participant was asked to choose the most meaningful clustering of elements. The graph of the G-values often contains an elbow, or point, where the G-value drops off dramatically. That G-value may be an indicator of the grouping that the participant thinks makes the most sense. However, the G-value is only an aid. The participant's understanding that a particular clustering of elements is meaningful is most important. Earlier in the process, the participant named each of the groupings of elements within this cluster. Those names, which will be called components, were used in the following step.

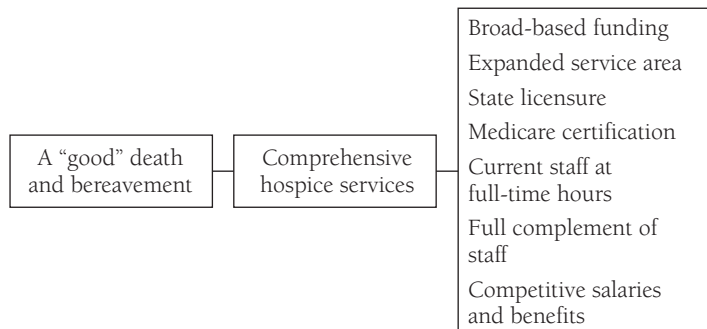
The next part of the individual meeting did not involve use of the computer. In order to arrive at a broad or overarching goal that addressed the components identified in the previous step, the participant was asked why each component was important. For instance, "staffing needs" might be important because adequate staffing is essential in providing comprehensive services. Next, the participant was asked how each component could be addressed. The resultant list might include the elements in the grouping from which this component was derived. However, the participant could add, delete, or modify the list.

The facilitator wrote the components in the center of the page with the overarching goal to the left and the more specific goals to the right. This process resulted in a treelike structure called a problem structure. One participant problem structure is shown in Figure 1.

Final Group Meeting

The purpose of this final meeting, which took approximately two hours, was to develop a group problem structure. Before the meeting, the participants' problem structures were drawn on newsprint. At the meeting, the participants shared their problem structures with

Figure 1. Problem Structure Example



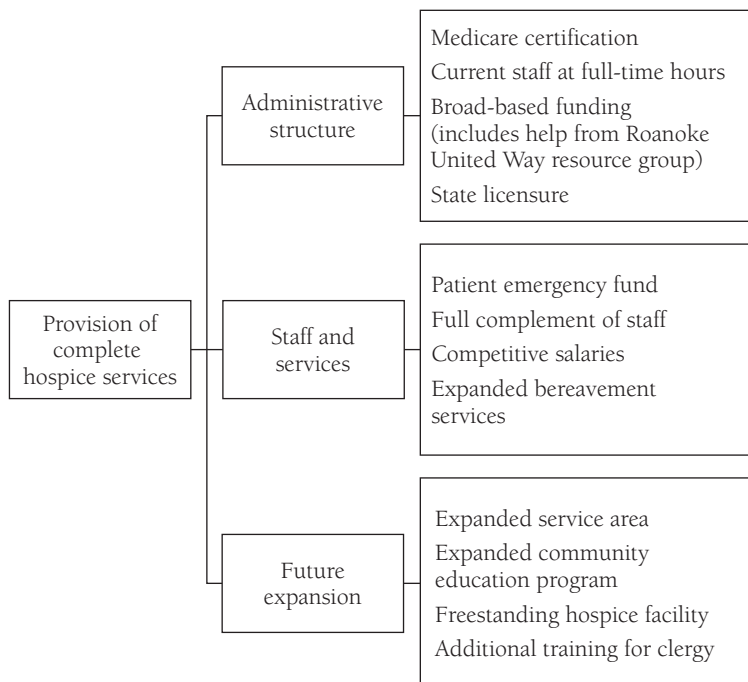
each other. From this interaction emerged the group structure shown in Figure 2.

In generating this problem structure, the participants first agreed on an initial list of components for the center boxes. Each time a participant suggested a component, the other participants were asked if they agreed with its inclusion. Discussion related to each component took place. The participants agreed that one area not addressed was that of a freestanding facility. They agreed that this goal would require more than ten years and decided to add the component, “expansion beyond ten years.” They attached the goal of a free-standing facility to that component. In the end, the following components were agreed on:

- Administrative structure
- Staffing
- Services
- Broad-based funding
- Marketing
- Expansion beyond ten years

The participants then formulated the overarching goal: “provision of the best hospice services in order to enable the patient and family to experience a ‘good’ death and bereavement.”

Figure 2. Consensus Problem Structure



Next, the group focused on specific goals to address the components in the center boxes. These goals are listed to the right of the boxes. For some of these goals, the group listed more specific actions to the right. Additional work (not included here) resulted in greater specification regarding the persons responsible for implementing each part of the plan and a timetable for completion of the tasks.

Participants' Evaluation of Planning Process

At the end of the group meeting, participants were asked to evaluate the entire process. One participant commented on her previous experience with strategic planning in other nonprofit organizations, saying those efforts had been inefficient and frustrating. She noted that the procedure used here focused the work of the participants, resulting in an efficient process. All of the participants said they appreciated the speed of the process. One said that she was "amazed" that it resulted in such a clear statement.

All of the participants liked the mix of group work and individual work. They said this combination provided prime opportunities for both introverts and extroverts to participate effectively. Extroverts were made to think before talking, and introverts were given time for reflection. One participant commented that she liked the way the computer work provided the structure for pulling information from her. She added, however, that construct formation was not an easy process.

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Evaluation in Terms of Goal Achievement

In 1998, eight and a half years after the plan's formulation, two key people in NRV Hospice, the executive director and a member of the board of directors, were interviewed in order to ascertain the degree to which the goals set in the strategic plan had been attained. This process was approved by the Institutional Review Board at the Pennsylvania State University. Both individuals judged that the overarching goal of providing excellent care had been achieved. Both said that clients expressed great satisfaction with the care received. Some problems, however, had been experienced in certain complex cases.

State licensure and Medicare certification were both achieved a year after the development of the plan. At the time of the interviews, preparations were underway for the acquisition of the hospice by a local nonprofit health care network. The acquisition, to be implemented in the coming year, was seen as a way of cutting expenses (through economies of scale), gaining more competitive salaries and benefits, and avoiding the formation of a competing hospice by the health care network. Board members, especially the member who was interviewed, were involved in these negotiations. Board development at the time of the evaluation therefore focused on the acquisition endeavor. Additional board members, with needed areas of expertise,

had been recruited. Certain board members, including the member who was interviewed, had been asked to continue in a similar capacity after implementation of the acquisition.

In terms of staffing, the positions present in 1990 were all full-time positions in 1998, and staff had been added. The number of hospice clients varies depending on referrals and deaths. Part-time or as-needed staff members are employed during times when client numbers (and Medicare reimbursements) are higher. Thus, a full complement of staff has been achieved.

Salaries and benefits were thought to be adequate but not competitive. It was anticipated that the acquisition would result in more competitive salaries and benefits. Both interviewees noted that significant improvement had been made regarding office equipment and supplies. In addition, the hospice office had been moved to larger quarters to accommodate the increasing staff.

A full range of services was offered and comprehensive client care provided. Community education programs were offered several times a month. A training module had been provided to clergy, and additional modules were being planned. Bereavement sessions continued for families and friends of hospice patients. An expanded effort was made to reach bereaved individuals who had not previously received hospice services. Publicity tools were developed.

The United Way, churches, and civic organizations had played lesser funding-related roles since the implementation of Medicare reimbursement. An assessment of fundraising activities resulted in additional efforts. A sliding-scale fee schedule was established but had been used infrequently; care continued to be provided regardless of ability to pay. A fee structure was established, as required by insurance companies and licensure. In addition to Medicare reimbursement, private health insurance companies that included hospice coverage in their policies reimburse for care.

A client emergency fund was established in 1986. Prior to that time, such needs were addressed as they arose. The health care network had agreed to put \$200,000 into a foundation that would be available solely for nonbudgeted needs of hospice clients. With regard to the goal of a freestanding facility (for an inpatient hospice unit), both interviewees spoke of the potential for such a facility in one of the health care network's current hospitals after the construction of a new hospital has been completed.

NRV Hospice therefore had achieved almost all of the goals in the strategic plan, resulting in an enhanced administrative structure; expanded staff and services; a broader, more stable funding base; creation of a well-defined market niche in the health care community; and the potential for a freestanding facility. By being acquired by a health care network, NRV Hospice could enter more fully into the managed care arena. Neither interviewee, however, said that the original strategic plan was the direct cause of the successful outcomes. Rather, actions taken as a result of the original plan triggered further

actions. These combined actions, for which the original plan set the direction, brought about the successful end.

Conclusion

Effective facilitation of the process is essential. A facilitator is needed who understands and can implement the Delphi process, is able to use the Situation Structuring computer software, can work effectively with both individuals and groups, and has a basic understanding of the organization for which the strategic plan is being developed.

Education may have played a role in the consensus that was reached by the NRV Hospice planning group and, in turn, by the board of directors. Prior to the planning sessions, board members and staff had been made aware of the changes that were taking place in the hospice environment on the local, state, and national levels. If prior education did contribute to the development of consensus, nonprofit organizations intending to use this process would be well advised to precede its use with a series of educational sessions related to the current environment of the particular organization.

The process provides nonprofit organizations with the potential to develop a strategic plan in an interesting, streamlined way that effectively uses the time of participants. Further application of the process is needed to demonstrate the range of its usefulness.

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Note

1. A copy of the Situation Structuring program can be obtained by writing to Dr. John Dickey, Center for Public Administration and Policy, Virginia Polytechnic Institute and State University, Draper Road, Blacksburg, VA 24061.

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