

C A S E 13

Life Images: 3-D Ultrasound

Martin B. Gerowitz

OVERVIEW

University Hospital has developed technology to create a three-dimensional image of targeted anatomy by enhancing traditional two-dimensional ultrasound equipment. This technology represents a radical improvement over existing imaging. It is believed that significant market potential exists for 3-D Ultrasound. In light of this, University Hospital seeks to identify the most advantageous strategic approach to exploiting this technology.

KEY ISSUES

1. Resolving and integrating a not-for-profit mission with a potentially profitable product.
2. The medical technology market is different from the health services provider market.
3. The number of strategic alternatives available for a cost-saving discovery.
4. Ethical consideration of a not-for-profit organization.

TEACHING OBJECTIVES

1. To illustrate the role of a mission statement in guiding strategic decision-making.
2. To provide an appreciation for selected market entry strategies such as: licensing, strategic alliances, and joint ventures.
3. To illustrate how the not-for-profit and for-profit objectives can be linked.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case engages students by requiring them to deal with strategic issues that surround market entry strategies. Students often have negative views concerning a not-for-profit hospital engaging in competitive behavior. Students should be queried regarding their assessment of any organization, for-profit or not-for-profit, to enter new markets or areas of production in which it may not have a history of prior competence. Those seeking venture capital or loans will attempt to paint positive pictures of market growth. Students should therefore be asked to critically assess market analyses.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Life Images' internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths

1. A significantly lower-cost alternative to MRI's and CT scanners.
2. Each organ requires its own software.
3. Upgrades can be a profitable market.
4. UH holds the patent.

Weaknesses

1. Not all body parts/organs are covered by the technology at this time.
2. Lack of marketing and manufacturing expertise.
3. Sales of technology is not a focus of University Hospital.
4. Developed on an Apple MacIntosh platform.

Opportunities

1. Cost pressures are constant and escalating for all sectors of the health care environment.
2. Greying of America.
3. Lower-cost, American technology is desired around the world.

Threats

1. The FDA regulatory approval process can be slow and is not a certainty.
2. The number of mergers and alliances among hospitals is decreasing the number of potential customers.
3. Hospitals buying physicians' practices decrease the number of physicians as potential customers.
4. Knowledgeable competitors with considerable financing and expertise.

STRATEGIC ALTERNATIVES

1. Strategic alliance.
2. Joint venture.
3. Internal development.
4. Licensing.

QUESTIONS FOR CLASS DISCUSSION

1. What is the mission of University Hospital?

The core business of the hospital as delineated in its mission statement suggests that the University Hospital is focused on teaching and research.

2. How does 3-D Ultrasound fit with this mission?

Any ancillary services or projects should support this mission. Development and marketing of 3-D Ultrasound can support the research and teaching focus by serving as an on-going source of capital, rather than as an end in itself. University Hospital is confronted with the need to develop a market-entry strategy compatible with its mission as a teaching and research facility. The appropriate alternative must reflect the financial, organizational, and cultural characteristics of the hospital to be effective. In addition, the strategy must consider the external forces confronting the hospital.

3. What are the regulatory, market demand, competitive and technological factors and their implications for entering the 3-D Ultrasound market?

Regulatory

The FDA approval process may take three months to two years given that 3-D is non-invasive and builds on existing technology. Time frames for approval can be affected by the knowledge and experience of the applying firm. If University Hospital attempts to undertake the process on its own, the time frame will likely be longer because they have no previous experience. The regulatory process in other countries can be less costly and facilitated by alliances with companies that have established familiarity with local markets and practices.

Market Demand

The potential demand for the product is substantial because each targeted organ requires its own software. In addition, each application has the potential for being upgraded and improved over-time. The market projections however, may be overly optimistic given the competitive pressures facing the health care industry. Mergers, acquisitions, and the formation of purchasing alliances among hospitals may create sufficient buying power among purchasers to reduce profit margins. In addition, the attempts to control the cost of health care by insurers may dampen the demand for physicians to purchase the equipment for their offices.

Competitors

Other companies should be viewed as potential threats. Ultrasound, CT scanners and MRI manufacturers tend to be well capitalized with extensive and experienced sales and distribution networks. GE, Seimens, and Toshiba are notable examples. These firms will have an interest in protecting existing markets by enhancing existing equipment or developing new and competing technology. On the other hand, these companies can be attractive partners; however they have indicated that they will not enter into a joint venture partnership unless the hospital is willing to put up financial capital in addition to the intellectual capital represented by the development team and the patents. The hospital could develop a joint venture with local venture capitalists to create a for-profit subsidiary which in turn could negotiate a strategic alliance with a large international firm to distribute 3-D Ultrasound.

Technological

The 3-D Ultrasound has been developed using an Apple MacIntosh platform. Because sales of Apple systems have been flat and declining in industrial applications, basing 3-D Ultrasound on an Apple system is risky for the long term. Continued research and development to allow the use of Windows operating systems may promote acceptance.

The introduction of any new technology requires training and support for the personnel who use it. Strategies need to incorporate the development of mechanisms for training and support. Failure to do so may limit the application of the technology and reduce the potential market.

4. What are the alternative strategies available to University Hospital for entering the 3-D ultrasound market?

Alternative 1 – Licensing

Licensing the 3-D Ultrasound technology to one or more vendors presents a low-cost method to rapidly diffuse the technology. This strategy offers the potential to expand into markets internationally without the administrative and manufacturing complexity of direct production.

Pros:

- Opportunity to spread fixed costs and increase revenues.
- Increased visibility and credibility for the hospital.
- Licensing can be easily done.
- Opportunity to expand the market geographically.
- Expand with less capital investment.
- May expand more rapidly.
- Learn and gain improvements from licensees or franchises.
- Potential for future expanded relationships with licensees or franchises.

Cons:

- No control over name equity.
- Complex legal issues are involved with franchising.
- May be expensive to exit the relationship.
- University Hospital will be responsible for enforcement of the licensing agreement.
- Training responsibility will require additional personnel.
- Administrative costs.
- Operating secrets cannot be protected.

Alternative 2 – Form a strategic alliance with a medical technology company

Pros:

- A partner would share in risk and profit.
- The market can be entered faster and with greater penetration.
- Other expertise can be gained from the partnering organization.
- Less up-front capital is required.
- Aligns interests of parties, eliminating some competition.
- Regulatory constraints might be circumvented.
- Facilitates true partnerships and long-term relationships.
- Increases opportunities for market share growth.
- It may be possible to spin off the entity – creating a for-profit venture.
- Builds credibility and strength in the community.
- Opportunity to create new organizational culture.
- Opportunity to do additional things – current flexibility and future development.
- Reduces administrative burden upper levels by parent organizations and reduces cost.
- May eliminate middleman.
- Reduces liability for parent organizations.
- Requires more businesslike approach.

Cons:

- Requires a new administrative structure.
- There may be significant difficulties in merging different philosophies (not-for-profit and for-profit orientations).
- Opportunity costs – excludes alliances with other suppliers.
- Loss of identity.
- The parent not-for-profit organization may lose control of the venture.
- It may be difficult to exit the relationship (exit barriers are high).
- Problems could negatively impact future ventures, e.g., possible expanded legal and financial exposure limits other opportunities.
- The future is tied to the success of the partner.
- Possible guilt by association.
- Risk of anti-trust violation.
- May take longer to make decisions.
- May require marketing and legal expense, i.e., new titles and logo.
- May trigger staff reductions.
- Venture partner could be bought out by hospital buyer.
- Increase competitors or stimulate competitor activity.
- Changes by supplier may affect ability to exit relationship.

Alternative 3 – Create a for-profit subsidiary

Pros:

- Cuts out the middleman – reduces the number of customers and provides more control over the subsidiary’s destiny and future.
- Closer relationships with customers.
- Customization and creative services could be focused on 3-D Ultrasound.
- Develop a prototype to enable other discoveries to be integrated.
- Administratively it is easier to keep such a different entity separate.
- Improves response time.
- Demands a shift in paradigm from being a services provider to a manufacturer.
- Greater accountability.
- Forces the organization to change quicker.
- A smaller, more focused organization can be proactive in responding to customer needs.
- The organization can focus on a long-term vision.
- Services integration will improve.

Cons:

- Internal development of the subsidiary requires a significant investment.
- The project requires greater internal complexity – including billing computerization, enhanced customer service, and greater investment in marketing.
- The close working relationship between the hospital and its subsidiary may alienate other vendors.
- Short term – the project will have a negative impact on revenue (i.e., vendors may exclude the hospital).
- Exposure to greater risk.
- Board acceptance or organization acceptance of shift.
- Demands a shift in paradigm (manufacturer).
- High risk as a sole strategy.
- Risk supplier alienation – hospital having more control.
- Demands better integration of services.

5. Which best fits the capacities and mission of University Hospital?

Because the hospital’s mission is focused on teaching and research, its expertise in launching a new product is minimal. This suggests that the hospital should stick to its strengths of research and development and leave the marketing and production to organizations with strengths in those areas.

That said, University Hospital should seek to develop a strategy that builds on its strengths and pulls in the services and expertise necessary to maximize income. Creating a for-profit subsidiary with venture capital only distracts the organization from its mission and does nothing to bring in additional required skills. Licensing on the other hand may not offer the income potential or commitment from partnering organizations

that would most benefit the hospital. Joint venturing allows the hospital to combine its expertise and patents with the marketing and production strength of an interested partner.

6. How would you implement the recommended strategy?

Joint venturing presents several issues for effective implementation, including development of the partnership agreement, income allocation, legal structure, personnel and staffing, and cultural blending. An approach that attempts to address these issues and positions the organization for a future public offering is the creation of a separate corporation with fifty-fifty ownership between the hospital and its partner. Board representation would be shared between the organizations. The hospital would contribute the patent, technical support, and a financial stake in the new entity. The partnering organization would contribute production capacity, access to marketing and distribution networks, and additional funding.

Spinning off the 3-D Ultrasound asset to a separate company allows the hospital to concentrate on its core business while allowing the new entity to grow and develop independently with its own interests in mind. Financial and legal risk is transferred from the hospital. As the entity grows, the hospital can choose to reinvest in the organization or receive periodic distributions. The preferred approach would be for all income to be reinvested into the organization for the first five years to generate a continuous history of growth, and to take the entity public after that time. The potential return at the end of five years would be expected to be substantially greater than the potential under any other scenario. Assuming an IPO with a conservative PE ratio of 15, the initial cash investment in the entity is expected to grow from \$4.5 million to over \$15 million.

CASE 14

The Veterans Administration Medical Care System

Sharon Topping and Peter M. Ginter

OVERVIEW

The Veterans Administration (VA) Medical Care System is the single largest centrally directed health care system in the United States. It has a budget of over \$9 billion and more than 350 facilities geographically dispersed throughout 28 districts within 7 major regions. It provides residency training for not only one-third of this country's physicians but also a large number of dentists, nurses, pharmacists, and other health-related professions. At the same time, it administers an extensive research program with a budget of well over \$150 million.

The issue in this case is the VA's current strategy. It is facing the 1990s with a \$221 million cash deficit, over 13,000 beds out of service, and more than 7,000 medical jobs vacant. To compound this are the threats of future budget constraints, substantial decreases in public spending, and an aging veteran population that will need greater levels of medical care. The students will have to assess the current strategy in order to determine if it will be successful given the current and predicted conditions and VA's ultimate purpose of providing quality medical care to this country's veterans.

KEY ISSUES

1. Developing an innovative future strategy that can provide quality health care in a time of budget constraints and at the same time meet the increasing needs of the veteran population.
2. Formulating strategy under political pressures with a diverse, but limited group of stakeholders.
3. Evaluating current strategy in terms of a hostile and restrictive future environment.

TEACHING OBJECTIVES

1. To allow students to compare alternative strategies and appraise their quality.
2. To provide the opportunity for students to debate the issue of strategic change given the VA situation.
3. To illustrate the complexities of strategic management in a highly unpredictable political environment.

SUGGESTIONS FOR EFFECTIVE TEACHING

Although this case contains information describing the VA's specific or task environment, it contains very little information concerning the general health care environment. Because of this, it may be better used following a discussion of the

changing conditions in the industry (see Case 1: Health Care Industry Note). This case requires students to identify and assess the existing strategy, evaluate the position and future outlook for the organization, and assess alternative strategies.

This case can be covered adequately in one class period. It can be used without the industry note (Case 1) or a discussion of the changing environment, but the student would gain a better understanding of the general health care environment with such a discussion. This case provides an in-depth description of the specific environment faced by the VA from which the students can identify and discuss the strategic issues.

Then, ask the students to identify the strengths and weaknesses of the VA Medical Care System. At this point, the students can identify the current strategy and then begin to evaluate the current and alternative strategies. The discussion can be ended with a debate as to what the VA should do.

The following written case assignment can be given to students for individual work or the class can be divided into small groups:

Congress has asked you to serve as a nonpartisan consultant (or consulting team) to evaluate the VA's current strategy. Include your appraisal of alternative strategies. Prepare a five to six page report giving your analysis, evaluation, and recommendations concerning the VA's strategic plan.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of the VA's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths	Weaknesses
1. Research program.	1. Dependence on the political process.
2. Education and training capabilities.	2. Congressional interference into operations.
3. Flexibility.	3. Budget constraints.
4. Extent of geriatric and extended care programs.	4. Staff recruitment and retention.
5. Lobbying power of veteran's groups.	5. Visibility created by the Cabinet position.
6. Reputation for quality long-term care.	6. Quantity/quality of hospitals in rural areas.
7. Efficient operations: regionalization and centralized purchasing and distribution.	7. Inappropriate use of beds for diagnostic purposes.
8. Provides one-class service for equity and equality.	8. Bureaucratic red-tape.
9. System-wide planning.	

Opportunities

1. Decrease in total veteran population.
2. Oversupply of beds in the private sector.
3. Surplus of physicians.
4. Acceptance of alternative care delivery systems.

Threats

1. Increase in AIDS and other debilitating diseases.
2. Changes in alternative sources of care (Medicare and Medicaid).
3. Nursing shortage.
4. Uneven population of veterans (Florida).
5. Aging veteran population and need for nursing home care.
6. Failure of “means” test.
7. Low income veterans.
8. Lobbying power of the American Medical Association.

STRATEGIC ALTERNATIVES

1. Market development – nursing homes.
2. Product development – outpatient and home care.
3. Market penetration – chronic disease, low-income maladies, alcohol/drug treatment.
4. Market development and penetration – all services to all vets and families of vets.
5. Retrenchment—acute care mainstreaming.
 - a. Joint venture with private sector.
 - b. Incorporate VA health into the military system.
6. Liquidate – integration into the private system.
7. Combination strategies – market development with nursing homes, retrench with acute care, liquidate and mainstream others.

QUESTIONS FOR CLASS DISCUSSION

1. What are the strategic issues facing the VA?

Before identifying the strategic issues, you may want the students to start by examining the general opportunities and threats in the external environment (listed in the preceding SWOT section). After discussing the opportunities and threats, the class can identify the strategic issues that face the VA Medical System.

A major issue is the aging population. With veterans over 65 peaking in 2020 at 47 percent of the veteran population, this is a major issue in the future. Another issue that complicates the problem even more is the profile of VA patients. They tend to be poorer with no insurance coverage, yet experience more chronic conditions. Both of these facts lead to another serious issue -- the need for nursing home care in the future. In 1990, it is estimated that the VA will provide nursing home care to 90 percent more veterans than in 1980.

Other issues that should be considered are the rising costs of medical care at the time that government is beginning to emphasize reduced spending. This leads to another point: the obligation of the taxpayer to the veteran for medical care. Other issues involve the failure of the "means test" (whether the veteran has the means from any other source to pay for health care) and the changes in Medicare and Medicaid allowances.

From the class discussion, the following issues should be identified on the board:

The aging population

- By 2000, 2 out of 3 males will be veterans over 65.
- By 2000, 37 percent of all veterans will be over 65.
- Veterans over 65 will peak in 2020 at 47 percent of the veteran population.
- People over 65 tend to have diseases that are generally more chronic and require longer hospitalization.

Profile of VA patients

- VA patients tend to be poorer and have more chronic conditions.
- About 45 percent of those receiving outpatient care were in low income levels.
- About 45 percent of VA users have no insurance coverage.

Need for nursing home care

- If VA were to close all extended care facilities, 50,000 elderly veterans would have to be shifted to community health care facilities.
- In 1990, it is estimated that VA will provide nursing home care to 90 percent more veterans than in 1980.

Conservative presidential administration and emphasis on reduced government spending

Obligation of taxpayers to provide for medical care for veterans

Failure of “means test”

- Obligation to provide care to those having no where else to go.
- Large variance between VA income standards and federal definition of poverty.

Changes in Medicare and Medicaid allowances

2. What are the strengths and weaknesses of the VA Medical Care System?

For a summary of strengths and weaknesses see the SWOT analysis in the preceding section.

3. What is the VA’s current strategy? Has it been successful so far? Will it be successful in the future?

The current VA strategy is multifaceted and includes the following:

- Focus is on meeting the needs of the aging veteran now and into the year 2010 with the assumption that there will be no more wars.
- Removing the focus from hospitals to outpatient services and non-institutional care.
- Strengthening ambulatory and alternative services (adult care and hospital-based home care).
- No construction of new facilities except in areas such as Florida where the aging population is increasing.
- Concentrate efforts on conversion of existing hospital beds to nursing home care beds.
- Rely when necessary on state and community nursing homes.

Currently the VA strategy has been successful in providing medical care to veterans, however, in light of the environmental changes it may not continue to be the case in the future. If the demographic statistics are correct, the demand placed on the VA by the aging veteran will be so great that it will not be able to provide services at today’s quality standards. The current strategy is a result of extensive planning on the part of the VA and many of these problems have been taken into consideration. However, one question is whether the VA has done enough. Another concern is the

reliance on state and community nursing homes. This part of the strategy may need to be redefined.

4. What are the advantages and disadvantages of each of the alternative strategies?

One alternative that should be considered by the VA is that of mainstreaming services. With this, the VA would provide financing but not the actual medical services. Using a voucher, for instance, the veteran would be able to choose from among the various health care providers for care. With mainstreaming, there are a number of advantages: assurance of quality control, easy conversion to a national health care system if one were adopted, AMA support, elimination of costly renovations or replacement of old VA facilities, and provision of better access to care. On the other hand, there are certain disadvantages to consider: responsibility of the poor is shifted elsewhere, a similar system – Medicaid – is failing, budget problems are not solved nor is the problem of using the existing facilities.

Another alternative is the integration of the VA into the private health care system. This would allow economies of scale for both systems and eliminate duplication of services. This alternative does have the AMA's support and offers political acceptability. It certainly would require more coordination between the systems. The VA community/state nursing home program is a successful example of this alternative already put into practice. Disadvantages that should be considered are loss of centralized control and the possibility that it may not meet the needs of the aging veteran population. In addition to requiring tremendous coordination efforts, the budget problem would probably not be solved.

A focus strategy, such as specialization into long-term care, is another alternative to consider. The advantages from this are the lower costs that come with specialization and the provision of a distinctive competency. In addition, this would eliminate the reliance on state and community facilities and would focus on the problems of the aging veteran. It may lead to improved quality and possible budget reductions. On the other hand, disadvantages to consider are: duplication of services and facilities, the problem of medical care for low income veterans under the age of 65, opposition from the veterans' lobby, and loss of continuity of care.

A fourth alternative involves the continuation of VA as it is with additional emphasis placed on the construction of long-term care facilities. The advantages accrue to the aging veterans, for this makes them the focus of the construction budget. It is supported by the veterans' lobbying group. One of the limitations of this proposal is that all other problems aside from long-term care, are left unsolved. Further, it means a budget expansion which is politically negative in light of the budget deficit.

Integration with the military is another alternative. This is advantageous because it solves the military's problem of physician shortages, allows economies of scale, and eliminates the duplication of services. The disadvantages are: lack of political feasibility, lack of a solution for the budget problem, the military has a long

history of meeting its own needs, and the VA problems with the aging population may not be solved.

Some advocate that if the VA focused on operational efficiency, it could solve many of its problems. Advantages to this are improved management practices, elimination of substitution of higher cost inpatient care for that which is less costly, improvement of the budget, political feasibility, improvement of image in the community, and elimination of incentives to keep beds full. The disadvantages are: the emphasis on operational efficiency may not decrease the budget substantially, there is no objective evidence that large scale inefficiencies currently exist, and it may leave the system unable to meet its growing needs.

The last alternative to consider is that of expansion and broadening of the array of the services that VA currently provides. Some argue that not only should the VA treat the veteran but should also treat the spouse. Advantages are many: elimination of the substitution of more costly services for services of lesser cost, provision for patient continuity and quality of care, strength of lobbying support by veterans groups, possibility for reduction in costs, meeting the needs of the aging veteran and low income veteran, and increasing the probability that each type of service will be more appropriately used. On the other hand, there are two very serious problems. One is cost -- this strategy would result in a substantial budget increase. Another is that this type of action is politically unpopular.

5. What changes in strategy, if any, would you recommend for the future?

In this case, one of the major questions that needs to be addressed in evaluating the current strategy is: "Will it meet future demand?" The class should discuss this particularly in terms of the projected long-term care needs of the veteran. There is some doubt as to whether the switch in emphasis to home care and outpatient care will take care of the needs of the aging veteran. This is especially questionable when considering the profile of the veteran. Another consideration is the moratorium on construction of new facilities. The states are already having problems meeting long-term care needs and there are questions as to whether VA strategy will intensify these problems.

C A S E 15

Wills Eye Hospital: Can It Survive as an Independent?

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OVERVIEW

Wills Eye Hospital, founded in Philadelphia in 1832, was a comprehensive center for ophthalmology and other specialized health care services. Wills operated as an independent, not-for-profit organization. Although financially sound, Wills was not immune to the complex, turbulent, and increasingly hostile environment of the health care industry. The specialized hospitals in the industry, such as Wills, were particularly vulnerable to health care reform and the spiraling costs of new medical technologies. The challenge for Wills Eye Hospital was to chart a viable course through this minefield of threats. This called for creative and effective management of strategy.

KEY ISSUES

1. Survival for a specialty hospital in a managed-care environment.
2. Greying of America means increased potential but it is mostly Medicare business that is less desirable after PPS.
3. Developing strategy that is satisfactory to the multiple stakeholders of a health care organization.
4. Evaluation of potential alliance partners.

TEACHING OBJECTIVES

1. To recognize the impact of a highly volatile and heavily regulated industry environment on organizational strategy.
2. To understand the special challenges of managing a health care institution into the twenty-first century.
3. To give students the opportunity to think creatively about strategic responses to current and pending health care threats.
4. To understand the importance of identifying and managing stakeholders in a multi-goal, multi-structured organization.

SUGGESTIONS FOR EFFECTIVE TEACHING

Wills Eye Hospital is a good case to use at the beginning of a strategy or policy course to emphasize the impact of the general environment on strategic management. The dynamics of the environment/strategy linkage are clearly evident. In addition, the case is well-suited to an application of the stakeholder management model.

After a discussion of the environment/strategy relationship, this case will provide real-life examples of the importance of the environmental scanning and SWOT analysis steps in the strategic management process. The case is particularly effective in highlighting the impact of the macro-environment on Wills' corporate-level strategy. That is, the real concern is not so much with competitive strategy, marketing, or positioning as it is with the impact of broad environmental forces and trends such as government regulation, technology and, to a lesser extent, demographics. The challenge for Wills is to continue crafting strategy under highly uncertain and threatening conditions that are ongoing. Wills made several strategic responses that have to be evaluated and decisions made about what to do next (largely beyond the control of Wills Eye Hospital).

The discussion questions listed below focus attention on various steps of the strategic management process. In using them the instructor can proceed through the case culminating with a discussion of strategic responses to the environmental threats identified by the students. The time required for case analysis will be at least one and one-half hours.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Wills Eye Hospital's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths	Weaknesses
1. Financially sound despite an increasingly hostile environment.	1. Highly dependent on one major specialty (ophthalmology).
2. An international reputation for ophthalmology, good corporate image.	2. Diversification efforts into hand surgery, geriatric psychology programs, brain surgery, and outpatient surgery centers have met with some success, but represent a small proportion of total revenue.
3. Recognized consistently by U.S. News and World Report as one of the top hospitals in the nation.	3. High proportion of Medicare patients.
4. Highly specialized and respected physicians.	4. Organization structure is cumbersome with both the CEO (Kessler) and the Ophthalmologist in Chief (Tasman) reporting directly to the board.
5. Relatively new building and facilities.	5. Wills is a publicly held trust; one of many held by the Board of Directors of City Trusts of Philadelphia.
6. Wills has generated operating surpluses in recent years and has accumulated a capital base of \$76 million.	6. Low occupancy rates.
7. A proactive management team.	

Opportunities	Threats
1. Health care reform poses both a potential opportunity and a threat.	7. Some medical staff are resistant to any changes that go beyond the treatment of the eye.
2. Some competitors in the region will need to craft strategic alliances in order to survive.	1. The health care industry is complex and volatile.
3. The greying of America should produce more need for Wills' most common operation (cataracts).	2. Increasing amount of uncompensated costs for care of the elderly and poor.
4. Increased emphasis on outpatient surgery as a means to reduce costs.	3. Attempts to control rising health care costs will continue, but the precise nature and effects of any legislation is very difficult to predict.
	4. Advances in medical technologies are VERY expensive but important for the continued survival of health care institutions.
	5. Demographic shifts are creating an increasing demand for health care services, especially among the older segments of the population.
	6. Competition in the general health care market in Philadelphia is intense, in part because the area is over bedded.
	7. Hospital closings and mergers.
	8. Predictions are that there will be four or five major systems in the area.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion/market development – Construct new outpatient surgery centers in locations outside Philadelphia.
2. Expansion/product development -- A new product might include development of expertise in diabetes.
3. Contraction/retrenchment – Return to a focus on the eye and become world renowned.

4. Contraction/liquidation – Sell out to one of the systems.

Market Entry Strategies.

1. Development/internal development – Wills has cash to pursue any number of internal development strategies.
2. Cooperation/merger – Determining a partner or the best system to join is difficult, especially when administration and medical staff have really set their goal to remain independent.
3. Cooperation/alliance – Less formal, slightly more autonomous alliances with others may have more appeal to Wills management.
4. Purchase/acquisition -- Wills has the cash to purchase another health care organization.

QUESTIONS FOR CLASS DISCUSSION

1. What will be the special challenges of managing a health care institution such as Wills Eye Hospital into the twenty-first century?

The health care industry is one of the most dynamic and challenging industries in which to manage. Both environmental and organizational pressures are responsible for the challenges. The more significant pressures from the external environment include:

- government regulation,
- demographic shifts,
- technological innovation, and
- internal management with diverse stakeholders.

Government

The spiraling costs of health care have resulted in the proliferation of government regulations and the resulting destabilization of the industry. The lack of consistency and predictability of federal legislation has contributed to a high risk/high cost health care environment.

Medicare/Medicaid: Medicare is predicted to be bankrupt early in the twenty-first century (the specific year depends on which figures you believe!); Medicare represents about 40 percent of hospital revenues. The federal government regulates Medicaid but leaves it to the states to pay for it.

Prospective Payment System (PPS): PPS has led to declining trends in hospital admissions and average length of stay; it has also indirectly fueled the growth of outpatient clinics, home health care, and other less expensive outpatient approaches to health care.

Demographics

The “greying of America” has put more burdens on the health care system and contributed to the Medicare deficit. Older Americans have more eye surgery than the rest of the population. Because they are on Medicare, the true cost of that surgery (at least at Wills) is not covered, requiring the hospital to absorb the increasing losses.

Technology

Advanced technologies are very expensive and difficult for hospitals, especially small specialized ones such as Wills, to afford. New medical technologies have shifted many types of medical services from inpatient to outpatient delivery.

Internal Organizational Challenges

There are also difficult internal challenges faced by health care managers. The major organizational challenge is the need to manage the diverse groups of stakeholders that share power within the institution. Managing the sometimes conflicting interests and the needs of these stakeholders is a delicate balancing act.

2. Identify and describe the key stakeholders of Wills Eye Hospital.

Wills, similar to other hospitals, has by stakeholders and constituencies that wield greater and greater influence on the organization’s operation. A partial list of key internal stakeholders at Wills includes:

- Board of Directors of City Trusts
- Executive staff (Wills’ top managers)
- Medical Staff (Physicians)
- Nursing Staff
- Patients

Board of Directors of City Trusts. Overseeing the hospital is the Board of Directors of City Trusts (because Wills was formed as a result of a bequest to the city of Philadelphia). The board is a group of political appointees that oversees not only Wills but 120 other organizations. The primary function of the board has been to review and decide the fate of new strategic initiatives developed by Wills’ executive staff. The Board is not particularly knowledgeable concerning the health care industry nor its opportunities and threats.

Executive Management Staff. This group would really like to keep Wills independent. Although they are doing every thing they can to maintain independence, market pressures are great to become a member of one of the four or five systems that are predicted for the area.

Medical Staff. The Medical staff includes physicians and nurses. Although nurses are regular salaried employees of Wills, the physicians are independent practitioners under contract with Wills (not salaried). Physicians rent space at Wills and may practice at more than one hospital. Most are attracted to Wills because of its fine reputation and

modern technology. As physician practices are purchased by hospitals, they will have little choice about where they perform surgery.

Government Organizations. Federal health reimbursement programs developed by the government have become key influencers of health care policy in the United States. Prospective reimbursement (PPS) plus Medicare and Medicaid reimbursement programs have demonstrated the vulnerability of hospitals to shifts in legislation. Controlling hospital costs and charges has become a major policy priority of the federal government. New legislation is likely, but difficult to predict.

Third-Party Payors. During the 1960s with the inception of Blue-Cross/Blue Shield in California, the business payment transactions of the hospital sector became removed from the customer and provider. In the 1990s, the use of managed care programs to attempt to cut costs has spread. Although still not dominant in the Philadelphia market, its penetration is increasing. Managed care will put particular pressure on Wills because it is not a low-cost producer. In addition, managed care organizations prefer to deal with a system that will provide total care at a negotiated (low) price.

Customers/Patients. The average health care consumer has become more and more educated with regard to types of services available and expectations concerning levels of desired quality. Much of this raised consumer awareness has to do with hospital marketing and the current literature available to the public. Although customers have higher expectations of quality, the cost implications have largely been left to others to manage. In the late 1980s and early 1990s, hospitals responded to the problem by segmenting their patient mix, stratifying customers into three groups -- the uninsured, the insured by government programs (Medicaid/Medicare), and the privately insured. It is the privately insured customers who make up the shortfall in operating costs through hospital charges (referred to as cost shifting) and who are the most desired patient. In the late 1990s, managed care has put even greater pressures on hospitals because they negotiate low costs for the significant number of patients they bring to the hospitals.

Special Interest Groups. The American Medical Association, American Nurses Association, American Hospital Association, corporate America, and insurance company lobbyists have all become powerful players in their attempts to provide health care at a low cost although not necessarily low prices.

Suppliers. Although suppliers of health care products remain in the background of the health care picture, the pharmaceutical and medical supply companies all represent a for-profit/not-for-profit interface with strong cost implications. Rising costs of medical products contribute to the spiraling health care cost increases.

Competitors. Competitors abound in this industry and become more powerful as the industry becomes more concentrated. The development of the hospital industry was originally anchored in communities. As a result, most communities sought to create a health care site that was nearby and provided immediate access to health care services. Particularly in urban environments, this resulted in many hospitals competing in common markets with common products. The result has been fierce competition for non-governmentally insured customers (a dwindling population), who can afford private health care services.

3. How has the implementation of the mission statement of Wills Eye Hospital changed over the past decade? Are these changes consistent with Wills' original mission?

The specific mission statement of the institution has changed. Although ophthalmology has remained the major focus, in recent years management has added new medical programs. New medical services being offered are hand surgery, geriatric psychiatry programs, brain surgery, and out-patient surgery centers (including but not limited to outpatient eye surgery).

The medical staff, who are used to thinking of Wills as a renowned eye hospital, have resisted expansion outside of ophthalmology. However, Kessler and his executive staff have prevailed for the need to diversify.

The founding mission statement of Wills included a commitment to the eradication of disease which resulted in blindness or contributed to a patient's physical deterioration, specifically "to care for the blind, the lame, and the indigent." Kessler believes that the new programs are true to this original mission as they respond to issues of impaired functioning of patients. Because brain surgery is similar to the delicate eye surgery, he sees them as complementary. In addition, he argues that by moving toward diversification, the hospital reduces its risk and vulnerability to the uncertainties of health care reform. Although the first argument is debatable (i.e., that the new programs are consistent with the mission), the point about diversification is compelling.

A further diversification could be in the area of diabetes. Diabetes is a disease that is a promulgator of blindness and a ravager of the body.

4. How important is it to Wills to form a strategic alliance?

Wills does, indeed, need the stability that would come from a well-designed and executed strategic alliance. Of course, this may not be immediately evident to the case analyst because of Wills' international reputation for quality eye care and the apparent financial health of the hospital. However, Kessler's predictions for a downturn of operating revenue came true as the organization moved through 1993 (see Exhibit 15. 7).

What is quite clear from data in the case is that because of the momentum for sweeping health care reform and the ever-increasing costs of remaining technologically advanced, Wills' viability was at stake. The rules of the health care game (i.e., industry structure) were changing and small specialized institutions such as Wills were especially vulnerable. CEO Kessler and his executive staff were genuinely concerned.

Technology in the field of ophthalmology had shifted medical procedures from in-patient to out-patient delivery at an accelerated rate and no slow-down was in sight. This had tremendous implications for occupancy rates at Wills. Filling beds would continue to be one of Kessler's highest priorities. Exhibit 15.9 shows that Wills had an occupancy rate of only 36.51 percent compared to rates ranging between 79 percent and 86 percent for nearby hospitals. This fact combined with the shifting patient mix toward a greater Medicare patient population and federal discussions to further limit Medicare reimbursements were all environmental threats that Kessler had little ability to change.

A strategic alliance might offer Wills added resources needed to weather this time of change.

5. What does Wills offer to an alliance partner that would benefit the partner?

Wills has an international reputation for quality eye care. Its medical staff is talented and its executive staff is respected in the industry. Although the case points out that the Philadelphia region is populated with health care institutions, Wills has no “competitors” in the area. It is the region’s only major ophthalmologic hospital. Thus, in allying with a nearby institution there would be no competition between the partners for patients. Rather, the partners could complement each other and could seek ways to cut costs through resource and technology sharing and raise revenues through patient-referral and possible new joint programs.

Exhibit 15-1 provides data on the Philadelphia Metropolitan Hospital Industry, comparing the years 1987, 1992, and 1995. Exhibit 15-2 shows the overall weak financial performance of Delaware Valley hospitals. In addition, as the case points out, the Delaware Valley Hospital Council reported that two out of every three hospitals in the city of Philadelphia and one out of every three in the surrounding suburbs ended fiscal year 1990 with operating losses. The losses were finally turned around in 1995 when the profit margin was 0.6 percent in the area. Average operating margins were between zero and one percent, far below the four percent margin that most health care experts say is needed to maintain the physical plant. Despite the statistics, Wills Eye consistently performed above the national average of 4 percent operating margins, until 1995. This alone made Wills Eye an attractive candidate for strategic alliances in the Delaware Valley.

6. What do any of the other actors offer that would benefit Wills?

Although there were a number of hospitals in the region, they had begun the process of forming systems. Therefore, the number of suitable strategic alliances were beginning to decrease. Exhibits 15-3, 15-9, 15-10, 15-11, and 15-12 provide data on potential strategic partners for Wills Eye Hospital. What is immediately evident in reviewing these exhibits is the disparity in size between Wills and other nearby institutions. The other institutions are three to five times larger than Wills in number of beds (capacity) and admissions. Thomas Jefferson is about ten times larger than Wills as measured by payroll expense and total revenue. Thus, one thing that some of these institutions may provide is a buffer between Wills and the expected environmental shocks associated with health care reform and technology procurement.

Of the systems listed in the case, two surface as potential alliance partners. The first is Jefferson Health System because of Thomas Jefferson Hospital and Main Line Health System. Jefferson had a fine reputation, was located immediately adjacent to Wills and the two have a history of association. In fact, the Ophthalmologist-In-Chief of Wills had an appointment in the Jefferson system as Chairman of the Ophthalmology Department. This dual appointment had facilitated the teaching and research partnership that Wills established with Jefferson and placed them in a position of close affiliation. Jefferson and its medical school complex were open to forming new alliances. The

concern for Wills, however, was the possibility of being overshadowed by its huge neighbor. As mentioned, Kessler was very sensitive to losing autonomy.

Main Line Health System, as part of Jefferson Health System, is one of the more powerful players in the Delaware Valley region. It had succeeded in building a corporate suburban structure that included Lankenau Hospital, The Bryn Mawr Hospital, Paoli Memorial Hospital, Bryn Mawr Rehabilitation Hospital and Community Health Affiliates. This multi-institutional system would give Wills access to the suburban Philadelphia population. Not only did this represent convenience for the patient, it would open Wills to a client base that had a higher proportion of private insurance coverage and was typically more affluent than its urban client base. An alliance with Mainline Health would establish a strong patient referral network from these suburban locations for highly specialized ophthalmic services and offer Wills the opportunity to fill more beds for their diversified services in both Geriatric psychiatry and hand surgery. Furthermore, as a collection of private general hospitals, there would be little duplication of services between Wills and the member institutions of the Main Line Health System.

A second, although less promising, alliance would be with the University of Pennsylvania Health System because of Presbyterian Medical Center (location of the Scheie Eye Institute). The combination of Wills with Scheie Institute could dominate eye care in the area. However, Presbyterian had a particularly poor year financially and was surviving only because of the University of Pennsylvania Health System.

7. If acquisition is a possibility, what is Wills worth? **

The value of Wills can be estimated using several approaches: book value; adjusted book value, and going concern value (capitalization of expected future cash flow). The financial calculations and assumptions for all three methods follow.

BOOK VALUE OF THE ENTERPRISE

Book value was calculated based on the following standard formula:

Total Assets -- Total Liabilities = Owners' Equity

Total operating assets	\$120,429,604
Total current liabilities	-7,906,032
Long term debt	<u>-11,620,000</u>
	\$100,903,572

BOOK VALUE OF WILLS EYE = \$100,903,572

ADJUSTED BOOK VALUE OF THE ENTERPRISE

Adjusted book value of Wills was calculated based on the following standard formula:

Total Assets (Adjusted) -- Total Liabilities (Adjusted) = Owners' Equity

Individual assets and liabilities are adjusted to reflect their current value or fair market value.

** The casewriters would like to acknowledge the invaluable advice by our noted colleague, Dr. Paul L. Foster, Professor of Finance at St. Joseph's University, on the financial methods.

In addition, the following assumptions were included in the calculation:

1. No adjustments were made to current assets because most current assets are reflected as cash.

2. Fair market value = replacement cost for plant, property, equipment (PPE) where,

Replacement cost = Book value of (PPE) + Consumer price index (CPI) – Depreciation

In this calculation we assume that (PPE) is in good shape and well maintained (12 year-old facility and up-to-date equipment) and as such the CPI from 1980-1995 is an estimated 65.6 percent (Bureau of Labor Statistics, 1996).

3. Also assumed is that Trust Funds go to the buyer, however a limitation from the buyer's standpoint may be a question as to who actually controls the "Funds and Investments" held by the Trustees.

CURRENT BOOK VALUE ON (PPE)

Original Cost	\$41,952,668
Depreciation	<u>-9,125,017</u>
Net (PPE)	\$32,827,651

Adjusted book value = Replacement rate on (PPE)

Replacement rate = Book value of (PPE) + (Consumer price index (CPI) or Inflation increment) – Depreciation

Original Cost	\$41,952,668
Inflation Increment (CPI @ 65.6%)	<u>27,520,950</u>
Difference	69,473,618
Depreciation	<u>-9,125,017</u>
Adjusted Book Value (PPE)	\$60,348,601

Total Operating Assets (Adjusted)	\$149,950,554
Total Current Liabilities ¹	-7,906,032
Long Term Debt	<u>-11,620,000</u>
Adjusted Book Value =	\$128,424,522

¹Total Current Liabilities assumed to be accurate as stated and require no adjustment.

TOTAL ADJUSTED BOOK VALUE OF WILLS EYE: \$128,424,522

GOING-CONCERN VALUE

The going concern value of the enterprise is a calculation based on the expected future cash flow and its value as a measure of a firm's worth.

Cash Flow = Funds Available for New Services and Equipment + Depreciation & Amortization + Bad Debt

A conservative estimate of the going concern value of Wills would be to capitalize cash flow based on the rate of return which could be earned on treasury bonds. Average cash flow capitalized at 6.0 percent (10 year T-Bond approximately 6.0 percent in January 1996).

Cash Flow -- 1992-1995

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>
Funds available	\$12,307,969	\$9,009,654	\$ 5,741,451	\$8,638,706
Depreciation and amortization	3,562,232	2,520,516	2,589,188	3,052,020
Bad debt	<u>2,387,888</u>	<u>3,430,931</u>	<u>3,551,890</u>	<u>4,015,654</u>
Cash flow	\$18,258,089	\$14,961,101	\$11,882,529	\$15,706,380

Average cash flow 1992-1995 = \$15,202,025

Capitalization rate at 6.0 percent of \$15,202,025 = \$253,367,083

GOING-CONCERN VALUE OF WILLS EYE = \$253.4 million

Using these above methods allows the case analyst to compare three different values as measures of the relative worth of Wills Eye Hospital at the beginning of 1996.

BOOK VALUE = \$ 100,903,572
ADJUSTED BOOK VALUE = \$ 128,424,522
GOING-CONCERN VALUE = \$ 253,367,083

The tremendous disparity between book value and going concern value of Wills has implications for both buyer and seller were Wills to look at an acquisition opportunity.

- a. If you were the Director of Thomas Jefferson Hospital, what would you offer for Wills?

Given the above calculations there is little doubt that the Jefferson Health System would open negotiation with an initial offer less than current book value of Wills (\$100.9 million). In fact, an opening bid of book value less 20 percent might not be an unreasonable starting point given that Wills has such tremendous excess capacity (i.e., unfilled beds and an occupancy rate of 36.5 percent). Jefferson could easily fill these beds for Wills and assure that Wills would be able to keep its current services in operation and intact. Jefferson could also guarantee that the current Wills management

staff would continue to manage the operation and the Board of City Trusts maintain its policy development role. The actual issue of governance has to be discussed at a later point in time. Were the Wills Executive Staff and the Board to turn down this initial offer, Jefferson could then submit an additional offer closer to current book value and be prepared to negotiate a final offer closer to the adjusted book value of Wills (\$128.4 million). This strategy would be appropriate only if Kessler assumes Wills worth is closer to the adjusted book value of the institution. Given this argument, it would be highly likely that an acquisition price would be negotiated between Kessler and the CEO of Jefferson.

On the other hand, as Kessler, I would reject the initial bid submitted by Jefferson countering this offer by stating that a more appropriate figure would be something closer to the going concern value of Wills Eye (i.e., \$253.4 million). Were Kessler to use this as an initial offer or counter offer to Jefferson, negotiations might be much longer. In this instance Kessler has a strong argument for estimating Wills worth at a higher rate given the amount of cash on hand, a building that is relatively new with state-of-the-art equipment, a world-renowned medical staff, and an international reputation for excellence in ophthalmology. The intrinsic value of the latter two variables gives him a very strong bargaining chip. In the final analysis, chances are good that the negotiated terms of sale would be much greater if Kessler would use this approach.

- b. If you were Kessler and one of the other potential strategic partners suggested it was time to negotiate, what terms would you suggest? How much control would you want over the alliance arrangements?

Kessler has indicated that maintaining the independence of the organization is a key issue. This issue, the case writers believe, is not just an expressed management objective but, is also reflective of Kessler's own personal preference as well. However times are changing and systems do not want to send patients out of the system because it means loss of control over costs. Wills will find it more difficult to receive referrals as an "outsider" (not involved in the system). Nevertheless, Kessler would want to set up arrangements that would allow him to maintain management control over operations. In this context then, he might look for linkages and opportunities that would not infringe on this control. Program-sharing, service-sharing, patient-referral network sharing, technology sharing and market sharing arrangements are all potential methods for establishing alliances with any number of partners. It would not be unreasonable to think that Kessler might even think about executing a spider-web strategy of alliances that would prevent any of the larger hospitals or multi-institutional systems in the Delaware Valley from attempting to acquire them. In fact, the idea of establishing a network of alliances would not only maintain independence for Wills, but would provide an opportunity to build an overall strength and presence of the alliance partners in the Delaware Valley.

8. What are the pros and cons of the strategic alternatives available to Wills? As Kessler, what would you do?

Despite the threats and the general state of uncertainty of the health care system, one option that students may identify which is not attractive is retrenchment/ liquidation.

Wills has always been viewed as the flagship operation of the Board of City Trusts. The notion of liquidation of Wills was neither a politically viable nor appropriate solution. Similarly, retrenchment appeared to be counterproductive for an institution that had the financial resources to grow and was already vulnerable because of its narrow focus and lack of diversification.

Likewise, a stabilization strategy would only maintain and incrementally improve the functional and operational nature of the organization. Maintaining the status quo in a field that was becoming increasingly unprofitable was not the answer.

The merger option, that is, Wills being acquired and merged into a larger institution was a very unattractive alternative for Kessler. The executive staff, headed by Kessler, was not in a desperate situation. The hospital was still a healthy institution. Furthermore, Wills had a proud and successful history in the Philadelphia area and the medical staff, the Board of Trusts, and the executive staff all wanted to maintain this tradition. Remaining an independent institution was a priority but one that may have to change. Being swallowed up by a larger institution and losing autonomy was not a desirable solution.

From a financial viewpoint, a Wills acquisition was a possibility. Wills, although small in size, had excess capital and could use it with Board approval, to acquire a small health care institution. This option, however, was not very appealing because Wills already had excess capacity (i.e., unfilled beds). Prudent management called for caution at this time. In fact, one could argue that the best use of the financial reserves at this time of high anxiety and uncertainty is to protect them in anticipation of more difficult times ahead.

The most viable corporate strategy options for Kessler were to seek strength and growth through strategic alliances or internal expansion of services. To that end, the strategic response for Wills Eye Hospital should be viewed from both a short-term and longer-term perspective.

The short-term perspective calls for an internal growth strategy primarily to expand and diversify the medical services and programs of Wills. This requires Wills to focus on and increase business in the outpatient surgery centers, and evaluate the desirability of allocating additional resources for the development of the brain surgery program. It is too soon to know whether these programs have made a significant contribution to the overall revenues of the institution. Kessler believes that both programs are consistent with the mission statement and business definition of Wills, but some of the medical staff disagree (as discussed above in Question 3).

In addition, as Exhibit 15-10 shows, the number of outpatient surgery cases continues to climb. This increase would call for Wills to undertake a market expansion strategy for out-patient services. Wills could establish more surgery centers in locations around the Delaware Valley. Positioning these units in other strategic locations would aid the hospital in more fully taking advantage of the shifting patient mix from inpatient to outpatient services. Current financial resources make this possible. These activities should sustain Wills' strength and capitalize on its current distinctive competence in the short run.

The longer-term perspective for Wills (three to five years out) will call for a strategy that is consistent with short-run positioning, but monitor the volatile external environment. If all area hospitals join systems, Wills cannot be left out. The internal growth short-run strategy should help to continue to offset dwindling occupancy rates on the inpatient side while the hospital executive staff examines the opportunity for a strategic alliance. As health care policy legislation focuses on capping health care costs and possibly establishing a prospective reimbursement system for outpatient care, Wills will increasingly be faced with carrying heavy overhead costs for buildings and beds that will be difficult to cover in the years to come. A joint venture strategy may well create the kind of network of strategic alliances required to survive in health care past the decade of the 1990s. The network of strategic alliances provides Wills with the opportunity to establish partnerships to cut costs or raise revenues. For instance, on the cost side, Wills could seek technology-sharing, program-sharing, and joint marketing efforts. On the revenue side, Wills could seek alliances to launch new programs. The short-run effort of the institution combined with its financial strength, international reputation, and management expertise should make Wills a worthy and attractive partner for a strategic alliance.

9. If you were on the Board of City Trusts what would you want to know about Wills before you voted on its strategic plan?

Significant questions management should attempt to answer for City Trusts board members:

- For Wills Eye, are regional, national, and international referrals increasing, decreasing, or remaining about the same?
- Is the hospital receiving national and international applicants of the highest quality to train at Wills?
- Are the occupancy rates increasing or remaining the same for eye surgery, hand surgery, and brain surgery?
- Are any other facilities providing eye care and treatment to a reimbursable population?
- Are any other facilities providing brain surgery to a reimbursable population?
- Is Wills financial margin less than, equal to, or greater than 4 percent?

C A S E 16

C. W. Williams Health Center

Linda E. Swayne and Peter M. Ginter

OVERVIEW

The Metrolina Health Center was started by Dr. Charles Warren “CW” Williams and several medical colleagues with a \$25,000 grant from the Department of Health and Human Services. Concerned about the needs of the poor and wanting to make the world a better place for those less fortunate, Charlotte, North Carolina’s first African American to serve on the surgical staff of the area’s largest hospital, Charlotte Memorial Hospital, created a health facility for the unserved and underserved population of Mecklenburg County, North Carolina. Dr. Williams died while the center was in its infancy and it was renamed in his honor.

After one year as CEO, Michelle Mars was proud of the past accomplishments of C.W. Williams Health Center, but was also concerned about its future. She observed that the health care environment was rapidly changing and wondered if C.W. Williams would have to align with one of the hospitals because of the growth in managed care in Mecklenburg County. In addition, she had an opportunity to purchase a new building, located in the heart of Center’s client base, that would serve more patients.

KEY ISSUES

1. Rapid environmental change.
2. Community health center management.
3. Horizontal integration (geographic).
4. Alignment with a hospital.

TEACHING OBJECTIVES

1. To acquaint students with the nature of and problems of operating a community health center.
2. To provide a means of discussing managed care and its affects on the management of health care organizations.
3. To develop a better understanding of health care networks.
4. To provide a forum for discussion of health care restructuring.
5. To understand the pros and cons of being affiliated with a larger health care network.
6. To provide a forum for developing strategy for C. W. Williams Health Center.

SUGGESTIONS FOR EFFECTIVE TEACHING

We have successfully used this case by breaking the class up into small groups to make formal presentations recommending a future strategy for C. W. Williams Health Center. We generally ask students to follow the normative model presented in Chapter 1 as an outline for making their presentations (external analysis, internal analysis, assessment of vision, mission, values, and objectives, and so on).

In addition to traditional graduate and undergraduate classes, the case has been used with health care professionals and executives. Again, typically we break the group into small groups and ask them to make a presentation recommending strategy. Usually we allow about an hour for group discussion and analysis and each presentation should last about ten minutes. These presentations can utilize some type of presentation software such as Microsoft Power Point or they may be developed on transparencies. Recently, with a group of health care professionals we provided the following outline to guide their thoughts and to assure that each group could compare its analysis with the analysis of the other groups.

Your Presentation

1. Situational analysis.
 - External issues.
 - Internal issues.
 - Mission/vision (directional) issues.

2. Recommended C. W. Williams strategy.
 - What has to be fixed?
 - What should C. W. Williams do?

3. C. W. Williams as a part of a network.
 - Would you want C. W. Williams as a part of your network?
 - What role should it play?

The transparencies of an actual presentation are provided in Question 9 of the Questions for Class Discussion in this instructor's note.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/ THREATS

A summary of C.W. Williams' internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths

1. Dedicated management and staff.
2. History of serving the poor population well.
3. Patients are satisfied with care and would recommend C. W. Williams to family and friends.
4. Debt-free.

Weaknesses

1. Very few non-governmentally insured patients use C. W. Williams for health care.
2. Limited space for the number of patients served.
3. Board involvement in day-to-day management (employee/patient “end runs”).
4. Insufficient personnel (need COO and financial officer).
5. Poor facility design/not enough exam rooms.
6. Difficulty of planning in uncertain environment.
7. Little awareness of C.W. Williams outside the traditional population served.

Opportunities

1. Managed-care experiments with the Medicaid population are occurring throughout the United States.
2. Rising costs of health care have increased the number of uninsured and underinsured.
3. Corporate downsizing and increased number of small businesses have left many previously insured working people without health insurance.
4. Federal grants and foundation grants to help less fortunate citizens.

Threats

1. Dominant systems in the area seeking to expand their patient base.
2. Rapid environmental change.
3. Increase in managed care (shift from fee-for-service to managed care).
4. Difficulty in recruiting physicians.
5. High cost and increased need for new technology.
6. External forces controlling managed care affiliation arrangements as well as market structure.

STRATEGIC ALTERNATIVES

Expansion/Market Development – Establish another health center location in the community.

Market Entry/Cooperation – Alliance with one of the two major hospital systems.

Expansion/Product Development – Hire physicians with different specializations, reducing the number of referrals outside C.W. Williams and increasing reimbursements.

Contraction/Liquidation – Sell out to one of the two major hospital systems.

QUESTIONS FOR CLASS DISCUSSION

1. What are community health centers? How are they different from public health departments?

In 1966 an amendment to the Economic Opportunity Act formally established the Comprehensive Health Center Program. By 1990 more than 540 community and migrant health centers at 1400 service sites had received federal grants totaling \$547 million. Community health centers have a public health perspective, however they are similar to private practices staffed by physicians, nurses, and allied health professionals. They differ from the typical medical office in that they offer a broader range of services, such as social services and health education. In addition, centers are typically owned by the community and operated by volunteer governing boards.

Federally subsidized health centers must serve populations that are identified by the Public Health Services as medically underserved. Half of these populations lie in rural areas. The other half are located in economically depressed inner-city communities. Approximately 60 percent of health center patients are minorities in urban areas whereas 50 percent are white/non Hispanics in rural areas.

2. How would managed care penetration affect community health centers? How might it affect C. W. Williams?

If the state sets up a managed care program that is highly structured and severely limits choice (to obtain the lowest costs through economies of scale), C. W. Williams may be eliminated as a provider unless they merge, sell out, or seek an alliance with one of the two major hospital systems. C. W. Williams was beginning to recognize the impact of managed care upon their strategy. For example, local physicians who in the past had the flexibility, loyalty, and availability to assist C. W. Williams by providing part-time assistance or volunteer efforts are now employed by managed care organizations or involved in contractual relationships that prohibit them from volunteering or working part-time. Other primary care solo or small group practices are struggling for survival themselves and seldom are available to provide services.

Further, although data was not always available, it appeared that C. W. Williams was being selected as the provider of choice by many of the Medicaid recipients. However, patients who failed to select a provider were randomly assigned and all Medicaid recipients were informed about all six of the providers. Fortunately, the presenters had stopped trying to explain the difference between managed care organizations and a community health center. Because C. W. Williams was known in the minority community, it was selected because of a comfort level. Others, however,

sought a managed-care program (such as Kaiser Permanente) that was used by more non-welfare recipients.

Still, Michelle Mars embraced managed care because patients must choose a primary care provider, patients were encouraged to take an active role in their health care, and there would be less duplication of medical services and costs.

3. Why has managed care been slow to develop in the South?

Managed care has been slow to develop in the South because of the nature of most southern states. Many of these markets are rural and therefore do not have the population base required for managed care to be profitable. Furthermore, the large urban areas such as Atlanta, Miami, and New Orleans were the first to be introduced to managed care. In addition to the rural and low population areas, many markets were dominated by insurers (such as Blue Cross/Blue Shield) that provided fee-for-service making managed care penetration more difficult. However, major changes began to occur in the 1990s and by 1996 managed care was being implemented in many areas of the South at an accelerated pace.

4. Does C.W. Williams need to affiliate with a hospital?

Affiliation with a large health care system would more fully integrate and broaden the range of services to patients of the center. In addition, recent developments toward the formation of a hospital consortium to contract with the state to pay for Medicaid patients would limit C. W. Williams' options for determining where their patients would receive acute care. Because C. W. Williams provides no inpatient or outpatient surgery, they have to have access to one of the hospitals for patient care.

5. What strategy do you recommend for C.W. Williams? Why?

The issue of market development (new location) is secondary to creating a clear strategy for survival in this changing environment. Although Marris has focused on this decision, it should be made only after a broader affiliation/structural strategy has been identified. It would seem that survival (success) is dependent more on being part of an integrated system of care than location. Clients must be provided with a full range of services comparable to other health plans (HMOs) and the system must be seen as stable and long-lasting.

Perhaps there are two approaches – aggressive or passive. The aggressive approach suggests aggressively entering into agreements to be a part of a system of care (even with Carolinas Medical Center). The passive approach suggests seeing how things “shake out” in the Medicaid system currently being developed.

After the broad strategy has been developed, location, facility, and management decisions may be better addressed. Developing a hierarchy of issues/decisions may be helpful in focusing management attention on priority issues.

6. What role should C.W. Williams play in a health care network?

C. W. Williams is a primary care provider and excellent not only in providing primary care but also in educating and involving their patients. C. W. Williams patients are extremely satisfied with their care and because of the education and social programs, the patients are treated at a much lower cost with very few malpractice claims. C. W. Williams is excellent in what it does. That said, it must be pointed out that the community health center does not have an outpatient surgery center nor can it provide acute care. Therefore, it must develop relationships with the hospitals. It serves the hospital by providing over 3,000 bed days largely reimbursed by Medicaid. Its patients are admitted appropriately and not in severe conditions because of lack of care. C. W. Williams is a valuable resource to a health care network. To become part of one – either Carolinas Medical Center or Presbyterian Health System – they want to be recognized as a contributor and retain some autonomy to continue serving the medically underserved.

7. Should C. W. Williams buy the site offered at a cost of \$400,000?

No. Remodeling costs were estimated to be almost that amount again. Reviewing the financials indicates that C. W. Williams cannot afford the approximately \$750,000 for making the location ready to see patients. This is especially true given the uncertainties of the market place. However, with the increased number of patients selecting C. W. Williams through the Carolinas Access Program, additional space will be required.

8. If you were Ms. Marrs, how would you handle the problem of the board members involvement beyond setting policy?

If the students are involved in the case, they typically are very strong in their reactions. The Board is comprised of a least fifty-one percent C. W. Williams patients – often uneducated and out of the workforce. Ms. Marrs has an educational task to teach these board members what their responsibilities are and are not. Ultimately, she has to put her job on the line if she wants to be effective: “Set the policies and judge my performance in carrying out those policies. If I’m not performing my job the way that I should, find someone else.” Her duties and those of the board are clearly specified in the articles of incorporation and bylaws. The Board needs to understand the difference between setting policy and meddling.

9. Prepare a discussion outline of your recommendations for C. W. Williams.

Situational Analysis

1. Two emerging systems, both diverse, with ambulatory, hospital, and insurance components.
2. C. W. Williams needs to align with a hospital system.
3. Most physicians are employed by a hospital system or have managed care contracts.

4. Hospitals need to align with C. W. Williams to prevent primary care in the emergency room.
5. Medicaid population is being channeled into managed care protocols.
6. Strong Kaiser health plan.
7. Consumers have greater choice in referral network.
8. Potential disenrollment is quite high (6 month recertification process).

Internal Issues

Strengths:

1. C. W. Williams' has experience with Medicaid population.
2. There is high patient satisfaction.
3. C. W. Williams has name recognition

Weaknesses:

1. C. W. Williams has a lack of strategic direction.
2. Lack of access to capital to improve operations and information system.
3. Poor management.
4. Board members do not have much exposure to changes in the health industry and are not trained in strategic management. The Board is too involved in operations.
5. Current facility may not handle patient volume.
6. Staff resources are stretched.
7. C. W. Williams' patients are not geographically dispersed.
8. Employees bypass management to go to the Board.
9. C. W. Williams engages in crisis management.
10. C. W. Williams may not be able to survive independently.

What Needs to Be Fixed.

1. Establish strategic direction with an implementation plan fully endorsed by the Board.

2. Approach both systems as potential alliances, however, C. W. Williams needs a partner with a strong information system that values patient education (alignment or merger may cause a clash of values/culture).
3. C. W. Williams should provide ambulatory care for the Medicaid population.
4. C. W. Williams could prevent emergency room abuse and add hospital volume for disproportionate share.
5. A partnership would identify resources to be shared such as space, physicians, finances, leadership and so on.
6. With an alignment, C. W. Williams would be better positioned to receive grants.
7. Outsource ancillary services such as lab, radiology, and sub-specialties.
8. Need to provide and promote wellness programs.

Network

C. W. Williams could be a valuable member of a network because it has:

1. A significant patient base that is educated concerning wellness care.
2. No debt.
3. A high level of satisfaction from patients.
4. Over 3,000 reimbursed bed days.

Role

C. W. Williams' role in the network could be as an ambulatory care center because it offers:

1. Primary care.
2. Appropriate referral for acute care.
3. Patient education and wellness training.