C A S E 17

The Visiting Nurses Association of the Greater Ledgerton Area

C. Louise Sellaro and Karen Lazarus

OVERVIEW

Susan Schelly was hired as Executive Director by the Visiting Nurses Association (VNA) Board in March 1992. She came with twenty years' experience in middle management at St. Steven's, a local 500-bed area hospital. Susan was one of the few non-nurses to head an area home health care organization, which precipitated a certain amount of distrust by many of the staff who assumed her role was one of financial management and cost containment, not commitment to quality of care or concerns for staff.

When Susan was hired, increasingly restrictive funding on the part of both private and government health care insurance providers along with the VNA's continued adherence to the philosophy of providing services regardless of a client's ability to pay, contributed to a deteriorating "bottom line" on financial statements. Some problems were immediately apparent. For example, although the number of billable visits was increasing, income received from insurance and other outside funding sources was decreasing, and the budget deficit was escalating.

At that time, Medicaid reimbursed the VNA at barely 60 percent of its costs, and private insurance companies were negotiating lower rates with the VNA; therefore the Medicaid caseload had to be reduced and the private insurance caseload increased. In addition, proposed cuts for Medicare and Medicaid included the possibility of a "co-pay" for both. The effect on home care agencies was expected to be additional paper work and more cash flow problems.

To add to the concerns, more for-profit and not-for-profit competition was emerging along with a shift to "managed care." Although some immediate impact on client load resulted from the competition, demand for VNA services was not appreciably affected at least initially. However, the financial squeeze extracted by increasing competition and the government regulatory "belt tightening" efforts aimed at health care financial reform eventually began to take its toll.

As the economic and political/legal threats continued, additional problems surfaced as VNA staff indicated a propensity to move from local to state and national level union representation. Both the Board and Susan were beginning to wonder if the VNA could survive.

KEY ISSUES

1. The health care industry presents some unique opportunities for alternative modes of delivery.

2. Increasingly restrictive reimbursement by private and government health care insurance providers.

3. VNA's philosophy of providing services regardless of a client's ability to pay.

4. Further Medicare and Medicaid cuts.

5. Increasing competition in the home care market.

TEACHING OBJECTIVES

1. To explore the issue of balancing cost containment and quality of care.

2. To illustrate how an emphasis on costs in the health care industry has shifted care into less costly settings.

3. To deomonstrate the impact of cuts in Medicare and Medicaid on organizations serving indigent clients.

4. To illustrate that strategic management, budgets, and organizational culture are important to the success of organizations that serve indigent clients such as the VNA.

SUGGESTIONS FOR EFFECTIVE TEACHING

For students, no specialized knowledge is required other than the ability to tap into the wealth of information that is available as hard-copy or on-line in academic, hospital, and medical school libraries. Using a traditional approach to organizational analysis and strategic development, students are asked to examine the macro, industry, and internal environments of a home health care provider organization. The case focuses on problem analysis and decision-making from perspectives of both the VNA Administrative Director and the Board of Directors. Sufficient information is provided to allow the student to analyze the extent to which each has responsibility for developing strategic actions.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Visiting Nurses Association of the Greater Ledgerton Area's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths	Weaknesses
1. VNA provides a breadth of services not available at other home health agencies.	1. VNA does not adhere to the budget.
2. VNA has a good reputation.	2. They have a poor promotion program.
3. VNA has withstood change over the years and is able to adjust to many environmental shifts.	3. The lines of authority are not clear.
	4. The information/communication system is not well managed.

4. The board is willing to act on some components of change needed (approved the software package).

5. The executive director is not in the nursing field and, therefore, is able to be objective about the VNA as a business.

6. The staff provides a wide breadth of services.

5. No strategic management or planning.

6. The board is entrenched in old ideas.

7. Board members are not concerned with or willing to be involved in fundraising.

8. The executive director appears to be ineffective as a leader and needs to be a better policy maker.

Opportunities

1. Patients are being discharged "quicker and sicker" from hospitals.

2. Home care is gaining recognition as a lower-cost alternative.

3. Care for the medically indigent has become a political issue.

4. Miniaturization of technology allows more sophiticated care to be offered in the home.

Threats

1. Government regulations.

2. Increasing competition.

3. Decreasing reimbursements for home health.

4. Dishonest people who take advantage of the system may raise the costs of home care

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Maintenance/enhancement – To retain its place in the community, the VNA is just managing to "stay afloat." The increasing expenses and decreasing proportion of viable market share are causing an erosion of support from several sectors of its local environment.

2. Expansion/penetration – Within the client base it now serves, through satisfying current customers with current services is the only way to remain competitive. Client volume, efficiently served, is a requisite to operating in the black.

Market Entry Strategies.

1. Internal development – New services that are more profitable could benefit the VNA if there are enough financial resources.

2. Cooperation/joint venture – The local hospital refers many home care patients. Can the VNA enter a cooperation or joint venture with it?

Positioning Strategy

1. Cost leadership – Based on the way the regulatory process affects reimbursement, a low cost strategy must be part of the modus operandi.

2. Differentiation – If the VNA has services available that no competitor offers, or offers specialized services at a competitive price, market share will become more secure.

QUESTIONS FOR CLASS DISCUSSION

1. Is the current mission of the VNA appropriate? Why or why not?

Some components are appropriate. The VNA provides quality health care for the whole community; however funding is becoming more restricted which impacts the degree of nonreimbursable services that the organization can afford to provide.

2. What goals and objectives are apparent in the deliberations and actions taken by the Board and the Executive Director?

Funds acquisition is one obvious goal. The Executive Director initiated the idea of fund raising, and initially the Board did investigate the possibility. However, there seems to be a conflict in terms of the Board's goal in this regard and their actual motivation to do anything about it. This problem exists for many not-for-profit human service agencies, in that Board members often are willing, but they really don't understand how to organize fund raising activities. Other goals include increased market share, wage increases for nurses, joint ventures, and building relationships with individuals and groups that help to increase the client base.

3. Is there any indication of the culture of the VNA?

It appears to be somewhat "laid back." Because the communication system is not well-directed, the atmosphere would be perceived as disorganized. This situation often contributes to an atmosphere of distrust, as failure to act or manage efficiently is perceived as apathy or ineffectiveness.

4. Is the structure of the organization appropriate?

As described it appears to be a logical framework. However, the geographic distribution of nurse supervisor and functional divisions may cause confusion and communication problems.

5. Using the approach to sector analysis provided by Porter, what substitutes for home health care exist in the industry? What barriers exist to entry? Who are the suppliers to the VNA? Is their power particularly relevant? What power is available to clients (buyers)?

Substitutes – Few

- Convalescent centers.
- Sub-acute care facilities.

Barriers to Entry – Relatively Low

- Breadth of services that need to be maintained in order to compete.
- JCAHO or Medicare certification needed for some reimbursement.
- Capital start-up costs.
- Established referral system.

Suppliers of Clients – Relatively High

- Physicians.
- Hospital discharge planners.
- Other referral agencies, such as insurance companies.
- Government and private insurance companies.

General Suppliers – Low

- Pharmaceutical houses.
- Medical equipment suppliers.
- General office suppliers.
- Nursing education programs.

Buyers – High

- Private insurance.
- Medicare.
- Medicaid.
- Individual payors.

Note: It is useful to separate two types of suppliers in this Porter analysis – suppliers of clients and general suppliers. VNA is very dependent on upstream institutions for its clients. In addition, in the second category most suppliers have little impact on the industry. The notable exception is the supply of nurses. Without nurses, home care is not possible.

6. How does the power of home health care buyers differ from that of buyers in other industries?

Two types of buyers exist. The actual client (patient) and the insurers (known as third party payors). The actual client requests referrals from his or her physician who is often told by the insurer where services should be obtained to receive full reimbursement. Therefore the buyer has little power. The insurors have great power in that they dictate terms of reimbursement to the providers.

7. Compare and contrast the intensity of impact felt from the economic, political/legal, technological, and social segments of the environment.

These forces interact with each other. It is very difficult to determine the primary factor initiating macroenvironmental shifts. Economic forces and social forces interact to determine need for and accessibility to health care. As more individuals require health care, costs rise and political/legal forces are brought into play to regulate distribution of health care and make health services available to a broad spectrum of society. Technological forces feed into this process as more services are made available for a wide number of distribution sites. For example, kidney dialysis is now available in a portable unit that can be brought to a home health care client.

8. What steps are needed to implement the strategy of choice?

"Low cost" does not necessarily mean "lowest" cost, but it does mean being competitive. Overhead costs do need to be cut using every means available, such as bargaining with suppliers for reduced prices given for VNA's volume buying, examining processes to determine how they can be made more efficient (the scheduling software package is a good example of their move in this direction), and employee training to promote more efficiency in services provision. In addition an organizational structure analysis should be done to look for gaps in the communication network.

In providing differentiated services, demand analysis should be done for any new service to be considered. This may be a determining factor in deciding whether benefits (amount of remuneration based on market share) outweigh the costs of provision of the service. The efficacy of introducing a new product to differentiate services further is doubtful if there is no benefit to be gained from the addition.

9. What control methods should be set in motion?

Again, outcomes of employee training can be an important component of control. As people become more comfortable with their jobs and see themselves as part of a "larger picture" of the work place, culture will change, and work will flow more smoothly. This promotes greater accomplishments.

Benchmarking against other companies within or outside the community can also provide a comparison of efficiency and effectiveness in services provision. Finally, goals and objectives must be measured to determine progress.

10. Should the VNA mission be restated? What should be included?

In its current form, the mission statement really does not reflect the wellness component of care that has become a current focus for heath care in this country. The fact that client mix is essential to financial survival also precludes the viability of the "regardless of their ability to pay" issue. The role of employees, the breadth of technological expertise available to support clients, and specific services provided to children could be added to broaden the perception of a support base.

SUPPLEMENTAL READINGS

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Linda Himelstein, Gail DeGeorge, Eric Schine, Ann Therese Palmer, and Richard Melcher, "Is Fraud Poisoning Home Health Care?" *Business Week* (March 14, 1994), pp. 70-74.

Barbara Phillips, "That Nurse - Troublemaker," *World Health* 47 (1994), p. 15.

Mary Suther, "'High Tech' Home Health Care," *World Health* 47, no. 4 (1994), p. 15.

The Robert Wood Johnson Foundation, "Challenges in Health Care, A Chartbook Perspective 191," (Princeton, New Jersey: Robert Wood Johnson Foundation, 1994).

C A S E 18

The Premier Alliance Emerges

Linda E. Swayne and Peter M. Ginter

OVERVIEW

SunHealth Alliance was founded in 1969 by the state hospital associations of North Carolina and South Carolina as a shared services organization. Ben Latimer was appointed CEO and continued to lead and develop SunHealth for over twenty-five years. By 1995, over 150 partners in fifteen southeastern and south central states formed the alliance. However, the number of hospital mergers and affiliations in the 1990s made expansion of the alliance more difficult. In fact, as some mergers occurred, SunHealth actually lost some partners because the new system opted to use a different alliance.

Anticipating a shrinking number of potential partners, SunHealth began discussing a merger with Voluntary Hospitals of America (VHA). However, VHA's territory had some overlap with SunHealth's and its organizational structure was very different. Thus, when the CEO of the newly merged America Healthcare Systems (AmHS) and Premier Health Alliance approached Ben Latimer about a potential merger, he felt he owed it to SunHealth partners to listen. In actuality, it was a better match enabling an agreement to be reached quite quickly. Nevertheless, the three distinct cultures, orientations, and missions had to be integrated.

KEY ISSUES

1. Proper organizational structure for the new Premier alliance.

2. Encouraging member partners to purchase more goods and services.

3. Survival of alliances as hospitals become involved in networks and develop purchasing power without using alliances.

4. Strategic direction for an organization in a mature industry.

5. The challenges of leading a volunteer organization with over 350 "bosses."

6. Premier's positioning in the hospital alliance market.

TEACHING OBJECTIVES

1. To require students to develop and defend a strategy to the ownership group of a "voluntary" alliance.

2. To enable students to understand that not all growth is desirable.

3. To allow students to develop strategy for an organization that has successfully completed a major merger but now has to reinvent itself as a new organization.

4. To illustrate that all types of health care organizations are being affected by significant environmental change.

SUGGESTIONS FOR EFFECTIVE TEACHING

We have found that this case lends itself well to role playing. Students can be assigned the role of Robert O'Leary, Ben Latimer, and Alan Weinstein. Indicate to the students that they should role play the history of the organization they represent and try to develop a statement of mission for the new Premier. Exhibit 18-7 in the text summarizes key differences (reproduced on the next page).

If you want to involve many more students in the role play, add the new Premier Board: five to represent the old AmHS, five to represent SunHealth, and five to represent the old Premier, plus O'Leary, Latimer, and Weinstein. Developing mission, vision, values, and strategic objectives should keep the students challenged. It certainly has been a challenge for the new Premier. Stress the importance of leadership in this situation. Simply managing will not do.

Exhibit 18-7 Comparison of AmHS, Premier, and Sun Health

	AmHS	**PHA**	**SunHealth**
Founded	1984	1983	1969
Leadership	1984-86 Charles Ewell 1986-95 M. Trout, MD 1995- Robert O'Leary	1983- Alan Weinstein	1969- Ben Latimer
Stakeholder Terminology	Shareholder	Owner	Partner
Geographic Strength	N.E.,Midwest, N.W.	Major Metro markets	Southeast
Number of Stakeholders	40 Shareholders	55 Owners	152 Partners
Number of Owned and Affiliated Hospital Units	925	280	355
Orientation toward fee-for-service	Low	Medium	High
Number of Employees	100	130	650
Purchasing Compliance	100% required, but dual source	Moving toward 80% required	Sole source with incentives
Corporate Structure	Patent Corporation and LLP	Cooperative Corporation c(6)	Cooperative Corporation c(6)
Revenues of Stakeholders	$36 billion	n/a	$24.8 billion
Collected Revenues of Division	$78.6 million	$28 million	$61.5 million

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths

1. Largest hospital alliance.
2. Group purchasing power.
3. Financially strong.
4. Reputation for quality services.
5. Visionary leadership.

Weaknesses

1. Diversity of mission, vision, and values of the three merging organizations.
2. Organizational cultures not yet merged.
3. Redundancy of services offered across the three organizations.
4. Voluntary organization, little allegiance.
5. Slowness in decision-making; policy changes have to be approved by the Board.

Opportunities

1. Health care reform.
2. Continued business and public pressure for cost containment.
3. Aging of American population.
4. Continued escalation of technology.

Threats

1. Health care reform.
2. Emergence of new competitive format (integrated delivery systems).
3. Competitive national alliances (VHA).
4. Competition among hospitals limits potential new partners in any given market.
5. Many independent hospitals belong to more than one purchasing group.
6. Industry consolidation.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion through market development – some areas of the country are not served by Premier or different health care organizations, target markets, or market segments could be included.

2. Expansion through product development – building healthy communities requires some new products that are less well identified by hospitals.

3. Expansion through penetration – stimulate current members to do more purchasing from Premier because of lower prices.

4. Maintenance of Scope using enhancement – improve service.

Market Entry Strategies.

1. Cooperation through joint ventures – pursue new ways to cooperate with member hospitals or hospitals with each other or with different health care organizations.

2. Internal development for service area expansion – target geographic areas or segments that are unserved.

3. Internal development of new products – determine member's needs for the future.

QUESTIONS FOR CLASS DISCUSSION

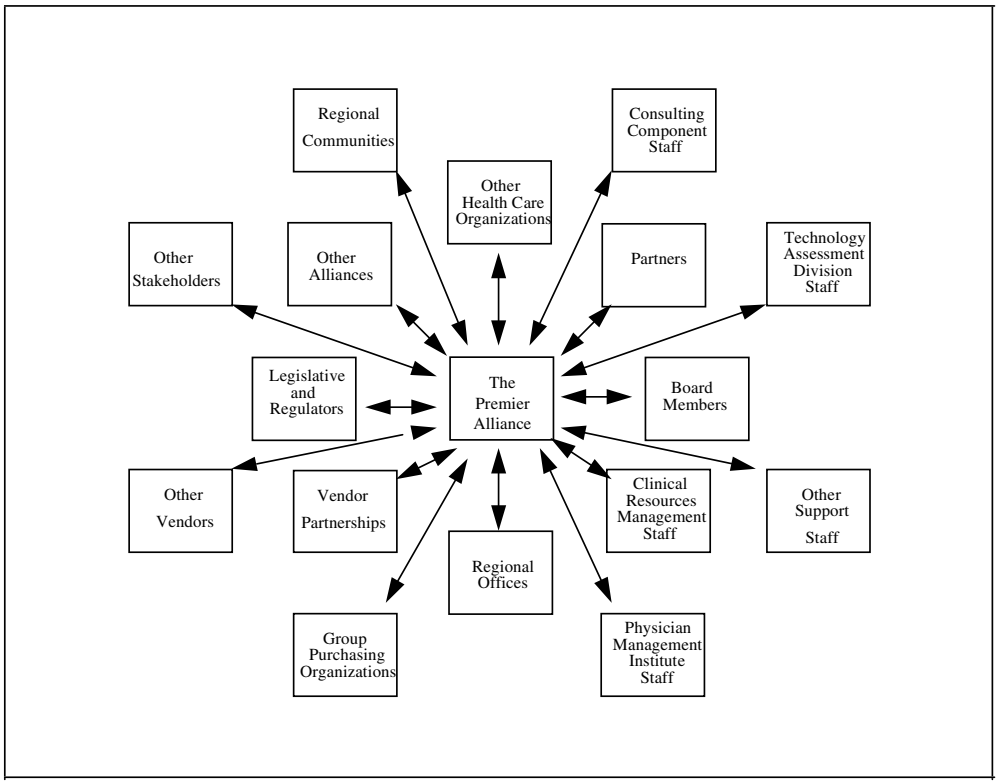
1. Are hospital alliances becoming dinosaurs in the health care industry?

Alliances can become dinosaurs if they do not serve their members. The number of hospital networks is increasing and logically it could be assumed that would lead to the demise of alliances. However, those who are quick to jump to that conclusion have failed to recognize the still predominantly regional nature of health care delivery. Regional medical practices differ as well as preferences for different types of medical products, such as X-ray film. To assume that national hospital networks will be developed and generate the same purchasing power as Premier or VHA, is not likely. Although a few for-profit chains, started in the mid 1970s have prospered, they still are not in many market areas.

On the other hand, a network would have greater control over units within its network and thus might be able to dictate purchases that would rival alliances' purchases in dollar amounts. For the most part, alliances rely on voluntary compliance to reach purchasing goals. By providing needed services at prices that hospitals perceive as fair, alliances will survive.

2. Develop a stakeholder map for Premier. Is it more or less intricate than that of other health care organizations?

Stakeholder Map for Premier Alliance



An alliance does have a slightly more intricate stakeholder map than other health care organizations because it must satisfy the typical host of external customers as well as internal customers (employees of various areas). However, its primary external customers are the owners of the alliance making them internal customers as well.

3. Develop SPACE analysis (strategic position and action evaluation) for Premier. What strategy does it indicate?

Strategic position and action evaluation (SPACE) analysis is an extension of the two-dimensional portfolio matrix used by the BCG. It is used primarily to strategically position the organization. Using SPACE analysis, the manager can incorporate a number of factors in the analysis and may examine a particular strategic alternative from a variety of perspectives.

SPACE analysis suggests the appropriateness of strategic alternatives based on the factors of the firm's financial strength, industry strength, environmental stability, and the organization's competitive advantage. Listed under each dimension are individual factors that are scored from "0" to "6." The numbers for each of the four factors are added together and divided by the number evaluated to provide an average score. The averages for Environmental Stability and Competitive Advantage each have six subtracted from them to yield a negative number. The averages are then plotted and connected to construct a four-sided polygon as shown in Exhibit TN 18.1. The resulting shape of the polygon can be used to identify four strategic postures -- aggressive, competitive, conservative, and defensive. The quadrant with

the largest area is suggested as the most appropriate general strategic position. The individual factors are evaluated for the Premier Alliance under the definitions of the four dimensions below.

Financial Strength. Premier Alliance enjoyed a good return on investment and high level of cash flow. Overall Premier is relatively strong financially.

Return on Investment	Low	0	1	2	3	4	⑤	6	High
Leverage	Imbalance	0	1	②	3	4	5	6	Balanced
Liquidity	Imbalance	0	1	2	3	④	5	6	Balanced
Capital Required/Capital Available	High	0	1	2	3	④	5	6	Low
Cash Flow	Low	0	1	2	3	4	⑤	6	High
Ease of Exit from Market	Difficult	0	1	2	3	4	⑤	6	Easy
Risk Involved	Much	0	1	②	3	4	5	6	Little

Average Score = 3.9

Industry Strength. There is growth potential in an industry that requires a high level of technical knowledge. Profit potential remains good and the industry must be viewed as relatively strong.

Growth Potential	Low	0	1	2	③	4	5	6	High
Potential Profit	Low	0	1	2	③	4	5	6	High
Financial Stability	Low	0	1	2	3	④	5	6	High
Technological Knowledge	Simple	0	1	2	3	4	5	⑥	Complex
Resource Allocation	Inefficient	0	1	2	③	4	5	6	Efficient
Capital Intensity	High	0	1	2	3	4	⑤	6	Low
Ease of Entry into Market	Easy	0	1	2	3	4	⑤	6	Difficult
Productivity/Capacity	Low	0	1	②	3	4	5	6	High
Flexibility, Adaptability	Low	0	1	2	3	4	⑤	6	High

Average Score = 4.0

Environmental Stability. There are many difficult to predict changes (particularly in technology) taking place and considerable demand variability. Substantial need for caution exists.

Technological Changes	Many	0	①	2	3	4	5	6	Few
Rate of Inflation	High	0	1	2	③	4	5	6	Low
Demand Variability	Large	0	1	②	3	4	5	6	Small
Price Range of Competing Services	Wide	0	1	2	③	4	5	6	Narrow
Barriers to Market Entry	Few	0	1	2	3	④	5	6	Many
Competitive Pressure	High	0	1	②	3	4	5	6	Low
Price Elasticity of Demand	Elastic	0	1	②	3	4	5	6	Inelastic

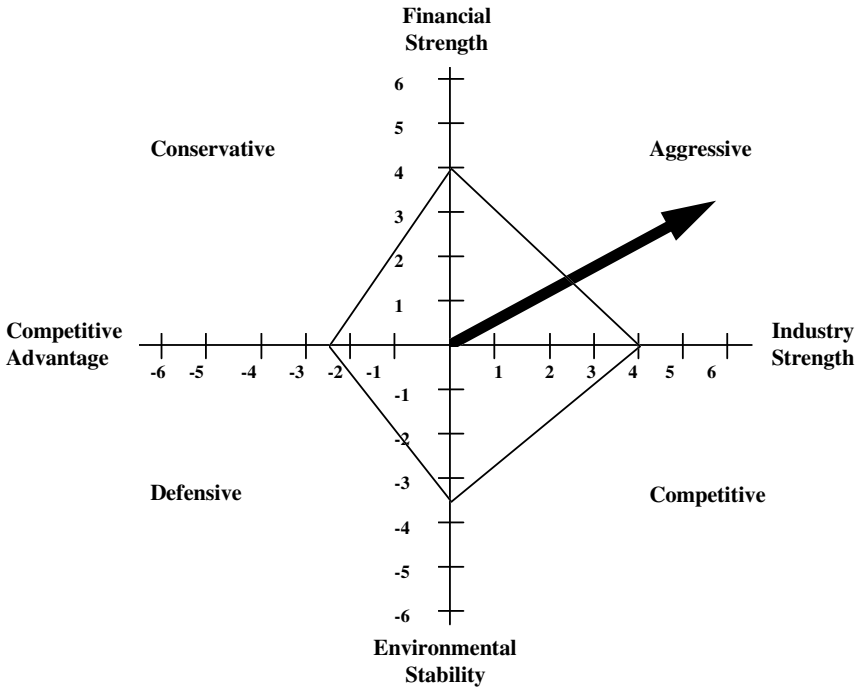
Average Score =
(-6) + (2.4) = - 3.6

Competitive Advantage. Premier has a competitive advantage centering on size, purchasing power, services quality, technical know-how, and it is member owned.

Market Share	Small	0	1	2	3	4	⑤	6	Large
Product Quality	Inferior	0	1	2	3	4	⑤	6	Superior
Product Life Cycle	Late	0	1	②	3	4	5	6	Early
Product Replacement Cycle	Variable	0	1	②	3	4	5	6	Fixed
Customer Loyalty	Low	0	1	2	3	④	5	6	High
Competition's Capacity	Low	0	1	②	3	4	5	6	High
Technological Knowledge	Low	0	1	2	3	4	5	⑥	High
Vertical Integration	Low	0	1	②	3	4	5	6	High

Average Score =
(-6) + (3.5) = - 2.5

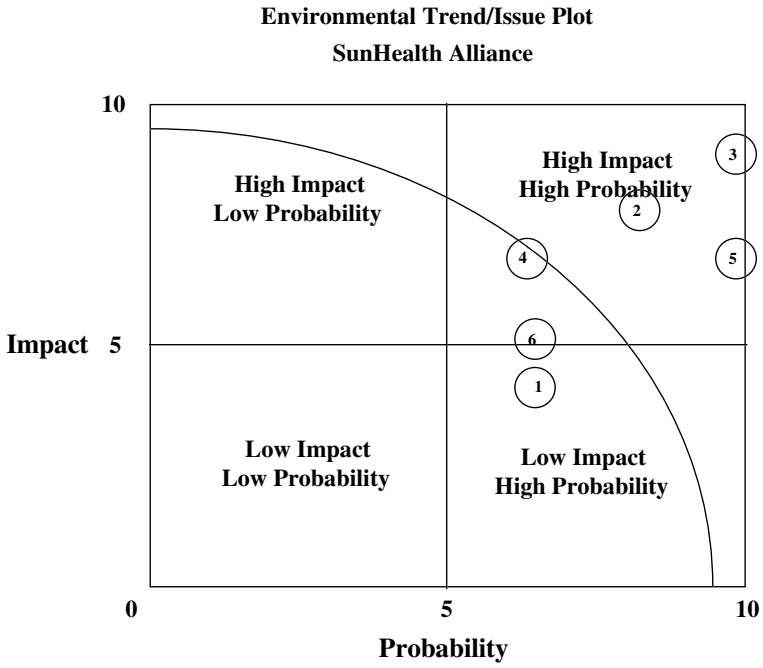
EXHIBIT TN18.1 SPACE Diagram for Premier Alliance



In the case of Premier, an aggressive posture is suggested, although the industry is maturing and a competitive posture may be appropriate in the very near future. This means that the organization may pursue a variety of strategies such as unrelated diversification and vertical integration.

4. What issues does the Trend/Issue Identification and Evaluation surface that Premier must deal with?

Trend #	Trend/Issue	O/T	Evidence	Impact	Probability
1	Increased competition in group purchasing	T	Many group purchasing organizations exist and the number is increasing; they require no time commitment	4	7
2	Mergers and acquisitions of hospitals	T	Significant number of purchases or mergers of hospitals and hospital chains	8	8
3	Technology advancing	O	Medical informatics and advanced information systems design for administration and health	9	10
4	Decrease in numbers of inpatients	T & O	PPS encourage release from the hospital sooner, more outpatient care, home care	7	7
5	Aging population	O	Elderly are increasing as a percent of the population; they require greater care	7	10
6	Increase in preventive care	O	Changing reimbursement practices and emphasis on primary care	5	7



The issues that Premier must deal with are those in the High Impact, High Probability quadrant: decrease in the number of inpatients and increase in outpatient care, the number of networks building within the health care sector, advancing technology, and the aging population.

5. Premier employees have developed a statement of values that has been approved by the Board of Directors. Would you have started with values or a statement of mission? Why?

O'Leary, Latimer, and Weinstein knew that it would take time to blend the cultures of the three organizations and that they needed to draw the employees into acceptance of the new Premier. It was easiest to start with the statement of values and many employees at all levels could be included.

6. What should be the mission for the new Premier Alliance?

This is very difficult given the histories and leaders of the three merging organizations. In addition to buying opportunities, old Premier and SunHealth offered a variety of services to a large number of smaller hospitals. AmHS, however, was more focused on national programs because its members (as systems) often hired expertise for the entire system and did not need the types of services offered by the old Premier and SunHealth. AmHS was more of a risk taker with early efforts at offering a managed care/risk product. Although it failed, AmHS was ready to try again especially given the changes that were continuing to occur in the environment. The old Premier and SunHealth were more conservative and focused on member services. All three organizations perceived the need for size, given the current merger/acquisition strategy of hospitals.

AmHS had the most cash, the largest hospitals, and a dominant leader in O'Leary. Latimer had develop the first hospital alliance and had the longest tenure as a leader. Weinstein had very loyal members in a smaller but wealthy alliance. The one thing they did seem to agree on was that the role of an alliances was to improve the health of the communities it served. Generally student focus on this idea to develop a mission.

7. Is it overly ambitious for Premier to improve the health status of their members' communities?

No. As a statement of vision, improving the health status of their members' communities is excellent. What is difficult is being able to provide services to accomplish that vision when most of the communities are so diverse.

8. What unique problems does Premier have with strategic control?

Strategic control is particularly difficult for a voluntary alliance because there has to be reasonable consensus on the mission, vision, objectives, and values. Thus, it is likely that many do not agree with all aspects of the organization's direction and strategies for achieving it. Each member organization knows everything about Premier, but Premier only knows what the members want it to know about their individual organizations. Therefore, it is challenging to set objectives, measure performance, and correct for deviations. In addition, Premier negotiates prices for the alliance partners but does not warehouse or inventory the items. Premier has to wait for reports from the vendors to know how much purchasing has actually been done by members. As a result, they have to try to correct for deviations considerably after the fact.

9. How can Premier take advantage of the industry concentration (integrated networks and strategic alliances)?

First, and most important, Premier must satisfy current members so well that when organizations merge the member advocates maintaining association with Premier rather than the alliance of the other organization(s).

Second, Premier has to increase its clout with group purchasing so that the products and services it offers to members are at excellent prices. The merger was sold to the three organizations on the basis of improved purchasing abilities.

Third, Premier has to reinforce its image of being much more than a group purchasing organization. Its consulting services must be first rate with expertise in the most recent developments in health care policy, technology, and so on.

Fourth, integrated networks are going to continue to expand and will include more than hospitals. Physicians, out patient facilities, sub acute care facilities, long-term care facilities, and others will no doubt become "integrated." Hospitals are leading the way, however these other health care providers will need purchasing and consulting services. Premier is on the right track with the Physicians Management Institute.

Fifth, Premier must work to develop strong personal ties so that members feel responsibility and obligation to the "fraternity" of Premier members. This is probably the most difficult goal for any voluntary alliance.

Lastly, Premier needs to develop real expertise in capitated contracts. Now may be the right time to offer a risk product.

CASE 19

MMG: The Integration Journey Of The Midwest Medical Group

Shawn M. Lofstrom, Rhonda Engleman, Russel Rogers, Frank Schultz, and Andrew Van de Ven

OVERVIEW

This case describes the integration challenges confronted by the Midwest Medical Group (MMG) as it attempted to establish itself within the Midwest Health System (Midwest). Midwest was a large health care provider operating in the Twin Cities of Minneapolis and St. Paul and was pursing a strategy of fully-integrated health care – clinics, hospitals, and health plans together in one organization. MMG was responsible for the clinical practice business within Midwest. The case highlights the complexity of issues that arose along the journey toward implementing an integrated health care strategy. In particular the case illustrates that integration is a process that evolves over time and that occurs at multiple levels (MMG into Midwest, acquired clinics into MMG, physicians/employees into MMG/Midwest).

The case highlights the structural changes that were made within MMG as it attempted to integrate into Midwest while at the same time attempting to maintain its own MMG identity as a large medical group practice. These structural changes occurred as MMG gradually shifted its organizational focus from managing for efficiency to managing for care. During this time, senior leadership changes occurred as the first MMG CEO, who maintained strong ties outside MMG, was replaced by a CEO who was more focused on MMG internal issues, including a team-based management approach.

KEY ISSUES

1. Health care corporate and business level strategy.

2. Management of a large integrated health care organization.

3. Leadership and organizational complexity of integration.

4. Changing environmental conditions requires an organization to understand change processes.

5. Management of professional employees (physicians).

TEACHING OBJECTIVES

After analyzing this case, students will be able to:

1. Take an in-depth, longitudinal view of the challenges confronting an organization in creating an integrated health care delivery system.

2. Understanding that integration occurs at multiple levels within the organization.

3. Understand the multiple forces both external and internal to an organization that influence its evolution.

4. Explore the extent to which management of a complex organization is able to influence the organization's development.

SUGGESTIONS FOR EFFECTIVE TEACHING

Although it is possible to take this case in many directions depending on instructor preferences and the case's positioning in a course, we believe some of its most illustrative points revolve around the process of change that occurs over time as MMG attempts to manage the multiple challenges of integration. In particular, the case explores questions such as: What were the objectives that Midwest and MMG were trying to achieve throughout the process of integration? What were the challenges that were encountered along the integration journey? What structural changes were implemented in attempts to resolve these issues? What role can leadership play in the change process?

If this case is used as a way of addressing the organizational complexities associated with integration, a viable solution (there will be many) will propose a specific set of organizational structures and systems that support a strategy of health care integration. The solution will further demonstrate that the proposed structures and systems deal with the information processing, communication, and conflict management requirements necessitated by an integration strategy. Ideally, the solution will draw on established theoretical perspectives in support of its propositions.

If the case is used to generate a discussion of integrating multiple and diverse perspectives, a solution will propose the basic elements of decision making, structure, leadership, culture, and human resources practice (e.g., conflict management) that will facilitate the integration and leveraging (not squelching) of diverse perspectives. Such a solution will demonstrate how a particular structural mechanism (dual hierarchies) or leadership approach (leadership by negotiation rather than mandate) allows individuals representing different viewpoints to combine their insights in novel and organizationally beneficial ways. Once again, the solution will draw on existing theory as appropriate.

Finally, if the case is used to discuss strategies of vertical integration, a solution will state whether Midwest's strategy of vertical integration is or is not a viable strategy. This conclusion will be supported by data from the case and (ideally) by existing theoretical perspectives. The above exercise that compares the costs of ownership with the costs of transacting on the market is an example of the kind of analysis that would support a conclusion regarding Midwest's vertical integration strategy.

A discussion of this case might draw from any of the following theoretical frameworks:

Structural Contingency Theory: Configurational or "fit" theories of organization typically assume a correspondence between organizational strategy, structure, and environment (Thompson, 1967; Drazin and Van de Ven, 1985; Doty, Glick, and Huber, 1993). Midwest and the MMG are attempting to integrate three different activities -- primary care, tertiary care, and health care coverage -- in order to achieve a strategy of health care integration. The final organizational structure consists of three separate divisions or groups, one for each of these three activities. Separation of these three activities does not appear to "fit" a strategy of integration. Integration might be better achieved by organizing around consumers rather than around activities. For example, groups of doctors, hospital personnel, and health plan people could be created to serve particular consumer groups or geographic areas.

Information Processing Theory: The relationship between the three Midwest groups or divisions can best be characterized as reciprocal interdependence, that is, the outputs from one group become the inputs for another and vice versa (see Thompson, 1967). For example, after an initial examination, an MMG physician might prescribe a complex diagnostic procedure which is performed at an Midwest hospital. The output from the diagnostic procedure is then sent back to the physician who may use the information to decide whether to admit the patient to the hospital for treatment. Information processing theory suggests that reciprocal interdependence requires a high degree of information transfer and that this transfer is best facilitated by multi-functional groups or liaison/integrator roles (see Galbraith, 1977; Daft and Lengel, 1986). Relationships between the three Midwest groups could be improved through the implementation of these types of mechanisms. For example, hospital personnel, primary care doctors, and health plan people could be assigned to work together to address some specific community need (e.g., elderly care).

Resource Dependence Theory: Resource dependence theory suggests that organizations are interdependent with their environments and that organization structure and strategy is driven by an organization's need to gain access to resources in the environment (Pfeffer and Salancik, 1978). This perspective is useful in helping us to see why there is such a diversity of internal and external relationships between and among the different Midwest divisions and why these relationships are often both cooperative and competitive. Because Midwest is not a closed system, each Midwest group has a set of non-Midwest organizations that control resources critical for its survival. This fact has resulted in a complex network of cooperative and competitive relationships between each Midwest division and other groups both internal and external to Midwest (see Bunderson, Dirks, Van de Ven, and Garud, 1995 for a discussion of cooperative/competitive organizational networks). For example, the health plan needs to have strong relationships with Midwest-affiliated providers. At the same time, the medical group (MMG) needs to compete with Midwest-affiliated providers for payor resources (contracts). In other words Midwest (composed of the MMG and the health plan) is rewarded for both cooperative and competitive relationships with the same organization (affiliated providers). This web of dependent and interdependent relationships helps to explain why an action in the best interest of one Midwest division may not be in the best interest of another.

Professions and Organizations: The literature dealing with professionals in organizations can be used to help understand why professionals (such as physicians)

often make poor organizational citizens (Van Maanen and Barley, 1984; Wallace, 1995; Abbott, 1988). This literature suggests that whereas professionals value communities of autonomy and self-direction, organizations often seek to establish control and reduce intra-system variance through system-wide practices and policies. These different aims help to explain why professionals often resist organizational efforts to impose system-wide policies and procedures and why organizations often feel threatened by physician self-direction. The MMG's efforts to establish system-wide guidelines for clinical practice (described in the case) is a good example of this tension.

Agency Theory: Agency theory focuses on relationships where one party (the principal) delegates work to another party (the agent) and seeks to resolve problems that arise when principals and agents have conflicting interests/attitudes (Eisenhardt, 1989). The relationship between physicians and MMG managers is an example. When the MMG acquires a private practice, the role of an acquired physician changes from principal (part owner) to agent (organizational employee). This change restructures the risks and incentives for physicians and (often) results in lowered productivity (Grossman and Hart, 1986). The attempt by MMG managers to develop compensation systems that more directly reward physicians for extra effort is consistent with agency theory's prediction that principals will seek to develop contracts that reduce shirking and opportunism by agents.

Networks, Interorganizational Relationships, and Value Chain Alliances: Many people at Midwest view complete ownership (vertical integration) as the best means of accomplishing Midwest's strategy of integrated health care. Nevertheless, integration through ownership is not the only option. More and more organizations are seeking to streamline their operations by entering into "value chain alliances" (Lawrence and Gulati, 1995) wherein pieces of the value chain are performed by outside parties with whom the organization has a long-term relationship (Powell and Smith-Doerr, 1994; Jarillo, 1988). It may be that Midwest could achieve its objective of integrated health care delivery through a strategy of "virtual integration" by entering into networks of relationships with various health care players such as individual group practices. As mentioned above, a "virtual integration" approach would help to reduce the costs that Midwest incurs through the direct ownership of clinics and providers.

Transaction Cost Economics: Transaction cost economics suggests that organizations will vertically integrate as long as the cost of ownership is lower than the cost of transacting on the market (Williamson, 1979). The following lists, based on facts derived from the case, suggest some of the costs that Midwest incurs by owning the MMG as well as some of the costs that they might incur if they did not own the MMG. A comparison of these two lists can be helpful in an evaluation of Midwest's vertical integration strategy.

Costs of Owning the Midwest Medical Group. Lower provider productivity because of the removal of ownership incentives, inability to aggressively negotiate payor contracts because of the Midwest affiliation, costs of financing unprofitable but strategically important clinic acquisitions, and inability to compete with Midwest-affiliated providers because of Midwest membership.

Costs of Achieving Medical Group Cooperation through Market Transactions. Costs of negotiating and enforcing contracts with various group practices, costs of losing referral base because of competitor acquisitions, and possible lost opportunity to create a single point of accountability for health improvement.

In comparing and discussing these two lists, it should be noted that many of these costs can be influenced by variables other than ownership/non-ownership. For example, long-term, mutually beneficial relationships with providers can reduce the costs associated with market transactions.

Midwest Survey Results. Two findings from the 1995 Midwest Organization Survey provides some promising ideas for physician-system integration. First, the study found that although physicians are more committed to their profession and managers are more committed to their organizations, individuals' commitments to their organization and profession are positively correlated. These findings suggest that commitments to organization and profession are viewed in a complementary way by Midwest managers and physicians.

The second finding pertains to the four different models of organization discussed in the case that appear to drive the Midwest Health System: system, market, physician, and community. The Midwest survey found that these four different models of organization are positively (not negatively) correlated. This is true for what repondents perceived Midwest's culture to be now and what it should be in the future. As expected, physicians' ratings of physician- and community-driven models of organization are strongly positively correlated with job satisfaction, organizational commitment, and not thinking of quitting, whereas their ratings of the system and market driven models were uncorrelated with these factors. However, these factors were significantly correlated with all four models of organization for managers in MMG and the Leadership Forum.

These findings indicate that there is no zero-sum contest over the four different drivers of the Midwest organization; they are all positively correlated. Physicians have a more concentrated focus on the physician and community models of organization, whereas managers have a more diffuse focus on all four models. The perspective of the political scientist, James Q. Wilson, may be helpful to diagnose these findings. He argued that those with concentrated benefits or losses tend to mobilize power and political campaigns more effectively than those with diffuse benefits and costs. Wilson's argument suggests the need for Midwest managers to think about ways to concentrate benefits and potential costs of the four drivers of the Midwest organization, instead of treating them as loosely-coupled diverse interests in Midwest. The creative challenge is to concentrate the four views without eroding or squelching any one of them. The survey results show all four models of organization are positively correlated with one another, and each is related to increased job satisfaction, unit effectiveness, and commitment to the organization and profession for both Midwest physicians and managers.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Midwest Medical Group's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths

1. Midwest is a fully integrated health network.
2. Midwest is financially sound.
3. It is the largest health care system in the Twin Cities.
4. MMG's dual physician-management structure.
5. Only 25 percent of MMG physicians were specialists.
6. MMG's emphasis on care management.
7. Focus on local health care needs.

Weaknesses

1. MMG is comprised of 50 clinics, 475 employee providers, and 5,700 affiliated physicians.
2. A "melting pot" of organizational backgrounds.
3. MMG's dual management structure.
4. MMG has operated at a loss since its inception.
5. MMG's contribution to the bottom line is not easily identified.

Opportunities

1. Twin Cities market had wide acceptance of managed care.
2. Business Health Care Action Group is powerful and can award a great deal of business.
3. MinnesotaCare is innovative health care for the poor.
4. Improved, consistent quality of care through practice outcomes.
5. The low cost producer has a competitive advantage.

Threats

1. Physicians who see themselves as employees and provide minimal effort (poor organizational citizens).
2. Health care reform.
3. "Cookbook medicine" will emphasize the bottom line rather than individual needs for care.
4. Antitrust violation applied to health care.
5. Competition from private practices that are more patient friendly.

STRATEGIC ALTERNATIVES

1. Market development, horizontal integration – acquire additional practices.

2. Retrenchment – combine divisions.

3. Divestiture – sell off the division.

4. Value adding support strategy – further develop organizational structure to reflect the realities of vertical integration.

5. Value adding support strategy – further develop organizational culture to integrate individuals and groups from a variety of professional and organizational backgrounds.

QUESTIONS FOR CLASS DISCUSSION

1. What were the primary reasons why the Midwest Health System as a whole pursued an integrated strategy?

There were a number of reasons that Midwest was created as an integrated delivery system. They include:

- Response to the changing healthcare environment;
- Improvement in the quality of patient care;
- Achievement of cost reductions – vertical integration for economies of scale;
- Creation of a one-stop shop for health care needs – a single point of contact and accountability;
- Provision of seamless delivery for patient care across clinics, hospitals, and health plans; and
- Improvement in the health of the community.

2. What were the multiple levels at which integration needed to occur?

Midwest/MMG was pursuing integration at three levels:

MMG into Midwest**.** From the beginning, MMG was attempting to establish itself as a large independent group practice operating within the Midwest Health System. By creating a large group practice, MMG felt that greater cost savings and improved quality of care could be gained through standardization of processes and that greater negotiating power with health plans would be possible as a combined entity. These efforts at maintaining independence, however, were frequently thwarted by Midwest and the other divisions. For example, Midwest limited the capital spending that MMG could pursue and Medica (the health plans) reimbursed MMG at the lowest rates of any of its providers. The case discusses conflicts between Midwest and MMG related to accounting practices, performance measurement, operating costs, and MMG financial losses. Midwest's hospitals viewed themselves as the central focus of the organization and thought of clinics as mechanisms for channeling more patient volumes to them. MMG was constantly under pressure to pursue greater integration

of its activities with the health plans and the hospitals, but such efforts presented direct threats to MMG's vision of itself as an independent group practice.

Clinics into MMG. At the time of its founding, Midwest owned thirty-five clinics that had previously been part of Midwest's hospitals before the merger that created Midwest Health System. In its efforts to expand geographically, fifteen additional clinics were acquired throughout Minnesota and Wisconsin in 1995. Unfortunately, the financial viability of some of these clinics was suspect and the MMG ended up closing a number of them – further impacted MMG's poor financial performance. In addition, the process of integrating the clinics into MMG centered around how much centralization should occur and how much autonomy should be left to the clinics. MMG believed that centralization of activities such as information systems and billing could reduce the costs of care while standardization of care delivery could improve the consistency and quality of care the patients received. Many clinics, however, were threatened by these centralization and standardization efforts as they infringed upon the decision making and authority of the clinics. As a result MMG was constantly struggling to balance the needs of the larger group practice against the needs of each individual clinic.

Physicians into MMG. The primary integration challenge resolved around the major transition that physicians had to make from being entrepreneurs to being employees. Although the physicians who sold their practices to the MMG did so because the future of small independent medical practices seemed very uncertain, many physicians found the transition to employees to be a difficult one. From Midwest's perspective, the acquired physicians were not all living up to their expectations either. Most physicians on guaranteed contracts were not meeting their production expectations and 37 of the 55 clinics were operating below break-even production levels. The case describes that not all physicians responded to their loss of autonomy in the same way. Some welcomed the opportunity to focus on patient care and to be relieved of management related issues. Others felt that the MMG was undermining their ability to delivery quality care by limiting their decision making ability. The case discusses three different groups of physicians – those who were "on board" with the transition to MMG, those who were "on the fence," and those who became negative. The core factors underlying this group composition seemed to reside in physicians differing *willingness* and *ability* to contribute to MMG. Physicians who were on board with the transition felt increasingly empowered while those who were negative felt increasingly disenfranchised. Physicians who were on the fence mostly adopted a "lay-low" approach to their job.

In retrospect, Midwest was a bit optimistic in hoping that integration across the three businesses would automatically occur by having them within one organization. The case outlines tensions that arose related to accounting practices, performance measurement, strategic direction of MMG, rising operating expenses, MMG's ongoing financial losses, and capital allocation constraints. The original structure was found to perpetuate the traditional health care "silos" and did not encourage the level of integration across divisions that was necessary to achieve Midwest's objectives (as addressed in Question 1). The second organizational structure combined the hospitals and clinics into one division (Care Delivery Operations – CDO) with the intention of forcing them to work more closely together.

Through common systems – patient registration, medical records, billing – the hope was for costs to be reduced, care to be improved, and contract negotiating power to be increased.

The challenges that arose with hospitals and clinics in one division, however, centered on perceptions and distrust that the two businesses held of each other. The hospitals viewed clinics as feeder systems for their services while clinics viewed themselves as second-class citizens relative to the money making hospitals. Many in MMG were concerned that the move to the CDO was just an intermediate step on the road to regionalization. Regionalization would carve up Midwest's territory into districts based upon the locations of its hospitals. Clinics would then be associated with the region in which its primary referring hospital was located. Regionalization therefore was a threat to the existence of MMG as its clinics would be split apart into different reporting structures. This notion ran totally counter to all efforts by MMG to create a single large group practice. These efforts had been the primary focus of the MMG since the formation of Midwest. Many outside the MMG felt that MMG's efforts to integrate *within* MMG came at the expense of integration *across* Midwest. The hospitals and health plans did not believe that the MMG was attempting to further system-wide integration.

By 1996, concerns had risen significantly that Midwest would fail to achieve its stated objectives in pursuing integration. Not only was the MMG losing money, but the formerly profitable health plans and hospitals now were in the red. Many viewed the infighting that was taking place between the divisions as one of the primary contributing factors behind the poor performance. Too much time was being spent on resolving internal issues and this was taking time away from reducing costs and delivering patient care. In January 1997, Midwest senior managers knew a change needed to be made and were deciding between returning to the original organizational structure or moving the whole organization to regions (regionalization). In the end, they choose a return to three separate divisions for hospitals, clinics, and health plans. This organizational move reaffirmed the importance of MMG as a group practice and allowed the MMG to shift its focus from fighting for organizational survival to improving the quality of patient care. The origins of this latter objective had been set in motion by the elevation of physicians to roles as regional and district medical directors during 1996. Nevertheless, the return to the original organizational "silos" resurrected many of the longstanding tensions.

It is important to note that this sequence of restructurings over time helps illustrate the many conflicts that arose along MMG's integration journey. They also illustrate a key learning point that integration at one level (either horizontal or vertical) often directly conflicts with integration efforts at other levels.

3. What were the unique integration issues confronted at each level?

This third question is designed to get at the core problems being experienced by Midwest and MMG. One can argue that it was the strategy of creating a totally integrated health care system under one organizational umbrella that was at the core of the problem. Was the issue really one of finding the correct organizational structure or was it a deeper issue of the viability of an integrated strategy? If the issue

has not already been raised during the case discussion or during previous classes, this is an ideal time to raise the inherent tension that arises when care delivery and insurance functions exist within one organization. Maximizing patient visits enhances care delivery's bottom line while minimizing patient visits enhances insurance's bottom line. Is it possible to reconcile this tension within a single organization or must care delivery and insurance be kept at arm's length? It can be argued that structural changes cannot compensate for a strategy that casts integration in too broad a light. It is interesting to note that after the time period covered by this case, Midwest did in fact change its strategy by pulling back from its original stance on total and complete integration. Future organizational changes brought the hospitals and clinics into closer alignment (reigniting old tensions) but distancing the insurance business from the care delivery business.

4. How did Midwest and MMG's organizational structure change over time?

Midwest and MMG underwent three major restructurings during the timeframe of the case:

July 1994 to January 1996. During this initial period right after its formation, Midwest had three divisions (or groups as they were called) and a corporate staff reporting to the Executive Office (See exhibits 3 and 4). MMG was part of the Professional Services Group, which was focused on clinical care. Hospitals were located in the Delivery Services Group and health plans in the Health Plans Group. Within MMG, the structure was geographic with three regional vice presidents reporting to MMG CEO Dr. Hal Patrick.

January 1996 to December 1996. This second organizational structure (see Exhibit 7) combined the operations of the MMG with the hospitals into one division reporting directly to Midwest Executive Officer. The health plans remained in their own division, the Health Plans Group.. During this period within MMG, CEO Patrick gradually changed the titles and roles of the managers reporting to him from three Regional Vice Presidents to two Vice Presidents of Operations. At the same time, Patrick elevated the managerial role of physicians within MMG by creating Regional and District Medical Directors.

January 1997 to 1998. At the Midwest level, the third organizational structure was a return to its initial structure with the hospitals and clinics (as well as the health plans) in their own divisions. The structure of MMG within its division, however, was much different than the original MMG structure. MMG now had both District Directors (primarily of business backgrounds) and District Medical Directors (with medical backgrounds) jointly responsible for the operations of the clinics. Hal Patrick had been promoted to MMG CEO and Lief Erickson to MMG Executive.

Each of these structures was designed to address specific problems that existed prior to its implementation. In many cases however, the new structures created new problems:
The original organizational structure was Midwest's first attempt at bringing together the three different parts of the business (clinics, hospitals and health plans). This first organizational structure merely brought the pieces together under one organizational

umbrella, but did not involve any significant structural changes across the three businesses. The hope was that by simply bringing the three together under one umbrella that integration would then occur.

It should be noted that at the end of the case, Midwest is considering another reorganization that was to occur in combination with a change in their basic business model.

5. How successful were the new structures in resolving the problems they were designed to address?

This question is designed to encourage students to think more deeply about the complexity of managing the MMG as developed in the previous three questions. Although it is possible to identify the issues and critique the actions and outcomes retrospectively, the challenge for health care executives is to proactively manage an organization in this environment. This task is not at all an easy one. This discussion question will evoke a number of possible alternative approaches from students and can lead to a good discussion that reinforces the complexity of the situation. The fundamental question that the instructor should address, however, is to what extent can an integration journey such as MMG's be "managed"? To what extent can managers influence the direction of the organization and to what extent must managers merely "go with the flow"?

6. What recommendations would you make to the senior management of the MMG?

Focusing on improved health care for patients can be the umbrella that unites all of Midwest.

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C A S E 20

Sisters of Charity of the Incarnate Word Health Care System

Martin B. Gerowitz

OVERVIEW

The Sisters of Charity of the Incarnate Word Health Care System (SCHS) is a multi-hospital system serving communities in Southern California, Louisiana, and Southeast Texas. It has developed a system goal of emphasizing collaboration with suitable partners in the process of developing integrated community health networks that improve health status and meet the identified needs of the communities it serves. Each of the three markets faced a unique array of competitive forces in the form of increased bargaining power of purchasers and suppliers, product substitutes, reduced entry barriers, and jockeying among traditional providers. SCHS must assess its own strengths and weaknesses and determine appropriate strategies for implementing its stated objectives.

KEY ISSUES

1. Situational analysis may differ significantly for a multiple-hospital system versus the individual operating units.

2. Each market may require a different strategy based on differences in the competitive environment.

3. An organizational unit may not be able to compete and should be divested.

4. The use of combination strategies -- vertical integration (downstream), horizontal expansion, and divestiture.

TEACHING OBJECTIVES

1. To understand that a multi-hospital system is actually a portfolio of businesses.

2. To develop students' abilities to assess strategic changes in the environment and their strategic implications.

3. To illustrate structural alternatives for managing complex organizations.

4. To determine the factors relevant to selecting potential partners for alliances, mergers, or acquisitions.

5. To apply multi-attribute scaling techniques to decision-making.

6. To examine the pros and cons of vertical integration.

SUGGESTIONS FOR EFFECTIVE TEACHING

SCHS can be used effectively as a case that encourages students to recognize and deal with a variety of corporate and business level strategies. It is important for students to recognize that SCHS operates in these different regions, each with its own unique external environment as well as internal character and capacities. In many ways this case is really three cases in one, each requiring its own solution. Failure to recognize this point can create a great deal of frustration for the students. If the case is used early in the semester or the students are inexperienced with case analysis, we suggest telling the students to treat the analysis as three separate cases.

Students should begin to focus on the Southern California market and contrast it with the level of managed care competition in the Southeast Texas and Louisiana markets. In addition, they should compare the competitive capacity of the Sisters of Charity Hospitals in each market in relationship to bargaining power of suppliers (physicians and managed care plans) and purchasers.

If divestiture is considered for the California hospitals, students should consider conditions under which divestiture would not be consistent with the mission of SCHC, how they would use the proceeds of a sale, and the identification of a potential buyer.

In Southeast Texas, students should apply the given criteria to the selection of a potential partner and should consider the benefits and limitations of strategic alliances, mergers, and acquisitions.

Alternatively, the class could be divided into three (or four) groups. Each of the three groups could present its analysis for one of the assigned regions. To develop role playing, the three groups could present to a fourth group (system management) to "act" or not on the group's recommendation.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/ THREATS

A summary of Sisters of Charity of the Incarnate Word Health Care System internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths	Weaknesses
1. Devotion to its mission to care for the poor who are sick.	1. Devotion to its mission to care for the poor who are sick.
2. One of the top Catholic health care systems in the United States.	2. Geographic distance of system components.
3. Each hospital's administrator was given autonomy to meet the needs of his or her community.	3. Low involvement in managed care.
4. Emphasis on continuous quality improvement.	4. Decentralized leadership.

5. Strong financial position.

6. Development of a continuum of care.

Opportunities

1. West Coast markets have greater experience with managed care.

2. Outpatient care is increasing.

3. Business coalitions have expressed interest in direct contracting with hospitals that have developed an insurance capability.

4. Managed care is forcing physicians to form larger group practices and to provide an information structure for which they need capital.

5. A number of states have expressed interest in state-wide managed care contracts for employees.

Threats

1. Lower inpatient utilization – reduced demand for specialization.

2. Increasing market for managed care.

3. Alliances between practices and providers already cover a large percentage of lives in some areas.

4. Certificate of need (CON) laws by states.

5. National managed care carriers poised to enter various market.

STRATEGIC ALTERNATIVES

1. Market development.

2. New product development.

3. Acquisition.

4. Merger.

5. Strategic alliance.

6. Divestiture.

QUESTIONS FOR CLASS DISCUSSION

1. What are the differences in the external environments in Louisiana, California, and Southeast Texas markets? What are the implications for strategy?

   - The degree of managed care penetration.
   - The extent that the physician community has organized into large group practices.

- The size and mix of for-profit and not-for-profit hospitals.
- The concentration of large purchasers.
- The presence of physician-hospital organizations (PHOs) that have developed an insurance product.

The California market leads the United States in health care innovation. This market differs from the Texas market in that it contains many small hospitals and many large physician practices. The managed care penetration is 22.8 percent, double the U.S. rate. The mark of managed care, in California, is seen through the high number of mergers and alliances between physicians and between hospitals.

There is less than 10 percent managed care penetration in the Houston (Southeast Texas) market and most physicians were still in solo practice. National insurers were preparing to enter the Houston market and the Houston Health Care Business Coalition was formed to influence the direction of health care through its purchasing practices.

With a population of nearly 4 million people, Louisiana naturally divided into two distinct territories, northern and southern Louisiana. State government was the largest employer and the largest single purchaser of health care (when Medicaid enrollees were included). The state was considering a move toward capitated managed care. The state and other large employers in the chemical and oil industries who employed workers statewide were seeking the ability to sign statewide contracts to cover all employees.

2. What organizational design options does Urban have for promoting innovation and efficiency in SCHS?

SCHS needs to take advantage of both economies of scale and flexibility. A regional structure may provide some economies of scale while preserving flexibility that is consistent in each of the California, Louisiana, and Texas markets.

3. What are the advantages/disadvantages of strategic alliances over mergers and acquisitions?

Advantages

Strategic alliances are a means to create a service network that provides a wider range of services and broader geographic coverage. Alliance strategies provide opportunities for organizations with complementary services, complementary markets, and complementary management skills to reinforce quality and access. If an organization is weak in one of these dimensions, the formation of an alliance may produce a faster alternative for acquiring capabilities than internal development. In addition, alliances can provide a mechanism to achieve economies of scale through collaboration in the development of new information systems and to reduce duplicated clinical or administrative tasks through process reengineering and consolidation across institutional boundaries.

Disadvantages

Alliances do not provide the benefits of a full merger in that they do not consolidate assets nor management of the two organizations. This may make the necessary cost cutting decisions more difficult. The complexity of integrating the culture of the two organizations while maintaining the parent organizations' boards could create a bureaucratic nightmare in which decision making becomes slow and unresponsive.

4. Should SCHS develop its own managed care marketing and benefits-management capability for the Southeast Texas market? What are the advantages and disadvantages of entering the insurance business?

Disadvantages

The hospital may not possess the expertise to develop a managed-care product. It takes time and a particular kind of talent to achieve competence in structuring, selling, and servicing health benefit packages. Allying with an established insurer in a strategic alliance or partial ownership could reduce the capital requirements, would be faster than learning a new business, and reduce risk. In addition, it allows each party to contribute its distinctive competencies.

Advantages

Building an insurance product in an immature market could provide a competitive advantage -- especially if the plan could be rolled out quickly. SCHS is flush with cash, it does have experience as a third-party administrator, and is experienced in managed care through its operation of an HMO designed for CHAMPUS. Therefore, it may not have as steep a learning curve as others who would have to start from scratch.

5. Weight the importance of each of the criteria suggested by Gail Capazzalo. Are there other issues that should be taken into consideration?

The following is a typical ranking developed by students:

1. Cultural compatibility.
2. Market complement.
3. Product/service line complement.
4. Complementary strengths.
5. Ability to recognize, utilize, and compensate for each others' strengths and weaknesses.
6. Reputation and trust.
7. Shared values.

6. Utilizing multi-attribute scaling technique, determine how well each of the potential partners meets the above criteria in each market. Based on your analysis, recommend a course of action for SCHS in the California, Louisiana, and Southeast Texas markets.

Multi-attribute decision making uses a weighting scheme to establish the relative importance or impact of each attribute (or a strategy) of a decision criterion. The weighting scheme enables managers to compute a single, combined score for each alternative. The dialogue that surrounds the process of developing the computation helps to increase the decision maker's confidence in the chosen alternative.

The multi-attribute approach can be summarized as follows:

1. Identify the strategic goal (in this case a compatible partner for a strategic alliance).

2. State the alternatives available (Columbia/HCA, Hermann, St. Luke's, Memorial, Methodist).

3. Identify the decision criteria to be used in evaluating the degree to which the goal is achieved (C1 through C6 in this example).

4. Rank each decision criterion to establish its relative importance on a scale of 1 (low) to 5 (high). (For example, C3 is ranked a 2: given SCHS's strong financial position, the financial position of a potential partner may not be critical). See Table TN7.1.

5. Score how well each alternative (hospital) satisfies each decision criterion on a scale of 1 (low) to 10 (high). (For example, Columbia/HCA has an excellent financial position and is scored a 10 for that criterion.) See Table TN7.2.

6. Multiply the rank times the score of each criterion for each alternative. See Table TN7.3.

7. Compute the total weighted score for each alternative (Columbia/HCA = 117).

8. Rank the alternatives according to their weighted totals.

9. Choose the alternative, taking into account the objective and subjective benefits of each alternative.

Table TN7.1 Rank Relative Importance of Decision Criterion

Code	Decision Criterion	Rank of Relative Importance 1 (low) to 5 (high)
C1	Complementary geographic/service coverage	5
C2	Evidence of clinical quality	5
C3	Strong financial position	2
C4	Emphasis on integration	4
C5	Embrace physicians as partners	3
C6	Compatible values	5

TN7.2 Score of Decision Criterion of Alternatives

Alternatives	Decision Criterion Score Satisfaction of Decision Criteria, 1 (low) 10 (high)					
	C1	C2	C3	C4	C5	C6
Columbia/ HCA	2	5	10	7	8	2
Hermann Hospital						
St. Luke's Hospital						
Memorial Hospital	9	7	9	7	8	8
Methodists Hospital						

TN7.3 Weighted Score of Alternatives

Alternatives	Decision Criterion Rank X Score						Weighted Total
	C1	C2	C3	C4	C5	C6	
Columbia/ HCA	5x2= 10	5x5= 25	2x10= 20	4x7= 28	3x8= 24	5x2= 10	117
Hermann Hospital	5x	5x	2x	4x	3x	5x	
St. Luke's Hospital	5x	5x	2x	4x	3x	5x	
Memorial Hospital	5x9= 45	5x7= 35	2x9= 18	4x7= 28	3x8= 24	5x8= 40	190
Methodist Hospital	5x	5x	2x	4x	3x	5x	

California Market

The nature of the California market may preclude the success of a late entrant to the managed-care market. In addition, the small presence in the California market dictates consideration of divestiture, diverting the funds from the sale to its Louisiana and Southeast Texas markets.

Louisiana Market

General Health was the largest managed-care provider in the state, with nearly 140,000 enrollees. General Health proposed developing services for the Medicaid population. This corresponded with SCHS's mission to care for charity patients. In addition, it was complementary in geographic and service scope. Louisiana Health Authority was a state institution and was seeking to privatize Medicaid recipients. Dealing with a state bureaucracy might not be a good fit for SCHS.

Ochsner Medical Institutions offered complementary geographic scope with its base in New Orleans. It was highly respected and had developed a distinctive competency in medical group management.

Southeast Texas Market

Texas Medical Center (Methodist, St. Lukes, M.D. Anderson, and Hermann) serviced the same area as the SCHS hospital, urban Houston. It was aggressively moving toward physician integration. The CEO at Methodist had a reportedly strong personality and avoided the trend toward managed care. The alleged postures and actions of Methodist (charity care), Hermann (physician acquisitions), St. Lukes, and M.D. Anderson (merger) should raise questions in some minds.

HCA/Columbia was a for-profit organization. It did not share the same mission as SHCS for directly serving the poor. HCA/Columbia operated several hospitals in the Houston market, had significant financial resources, and was known to purchase competitors within a market and then close them down.

Memorial Hospital, similar to Sisters of Charity, had a long history in Houston and was religious based. Memorial served suburban Houston and had embraced managed care.

7. Does Columbia/HCA's volume buying represent a sustainable competitive advantage? Why or why not?

No. The not-for-profits have been able to create their own purchasing pools through collaborative relationships. Two of the major collaborative purchasing pools were the VHA and Premier. SCHS is a member of the Premier Alliance in dealing with hospitals and insurers.

8. What is the major danger in buying health care on the basis of cost?

Clinical quality will be compromised in order to reduce costs.

9. Using Porter's five competitive forces (entry barriers, bargaining power of purchasers, bargaining power of suppliers, product/service substitutes, and jockeying among existing providers), what must acute care hospitals be particularly concerned about?

Reduced entry barrier

- Elimination of certificate of need laws.
- Accumulation of reserves.
- Access to equity capital.

Bargaining power of purchasers

- Houston Healthcare Purchasing Coalition.
- State government of Louisiana seeking statewide contracts.

Bargaining power of suppliers

- Physicians organizing into large group practices.
- Hospitals forming purchasing cooperatives for medical supplies, pharmaceuticals, and others.

Product/Service substitutes

- Ambulatory/day surgery for inpatient surgery.
- Home health services for inpatient care or subacute care.

Jockeying among existing providers

- Alleged efforts to pay prices higher than fair market value for physician practices.
- Efforts to create mergers and alliances to counter the bargaining and purchasing power of employers and the supply power of physicians' joining into group practices.

EPILOGUE

In 1995 the SCHS and Memorial Hospital entered into a strategic alliance and created the Memorial/Sisters of Charity Health Plan. That same year the SCHS entered into a strategic alliance with Ochsner to develop a statewide health plan. The following year, Catholic Health Care West acquired the SCHS's hospitals in California.

C A S E 21

Building For The Future Of Public Health In Alabama: A Case Study In Public Health Capital Financing

Rueben E. Davidson III, Stuart A. Capper, and Mahmud Hassan

OVERVIEW

The case opens with a scene in the Alabama legislature where the ALDPH is about to win authorization for a bond issue to be backed by a tax on toxic waste deposited in an Alabama site. This scheme ultimately fails for reasons described in the case and leads to the development of the health services revenue backed bonds. The case presents an approach based on the use of a "health care authority" as the entity issuing the bonds. The legislation permitting the creation of such authorities was originally intended to permit counties to issue tax-exempt revenue bonds for hospital construction. Such authorities had not been used previously to fund public health facility construction. The discussion in the case presents the arguments in favor of the approach and begins to raise some of the concerns about risk and the changing health care reimbursement environment. Data are presented on the revenue sources for bond repayment and the intended uses of the bond proceeds. Exhibits include data from the actual bond prospectus and the legislation authorizing health care authorities in Alabama. The case ends with the final decision facing the state health officer, Dr. Williamson. Do we proceed with this unique, and possibly risky, method for obtaining new public health facilities or not?

KEY ISSUES

1. The advisability of the use of revenue bonds as a method for financing capital construction by a public health agency.

2. The possible impacts of the rapidly changing health care environment on the revenue stream projected for repayment of the bonds.

3. Methods to maximize the bond rating on this innovative type of bond issue, and the effect of the bond rating on overall costs.

4. The changing role of public health and the implications of these possible changes on the bond financing plan.

5. Assuring high ethical standards in the highly political environment that typically surrounds state bond financing, state paid professional services contracts, and state construction projects.

6. Impact of the need to repay bonded indebtedness on the overall incentive structure of state and local public health organizations.

TEACHING OBJECTIVES

Some or all of the following objectives may be relevant depending on the approach taken in teaching this case.

1. To allow students an opportunity to review and evaluate complex financial information in a public health setting to determine its relevance for making financial judgments.

2. To have students practice the identification of "key issues" that must be addressed when large scale or long term financial decisions are being made in the public health sector.

3. To have students generate alternatives to the financing plan proposed in the case and to debate and discuss financial and socio-political implications of alternative scenarios.

4. To have students practice the basic techniques of financial analysis in the context of a public health organization.

5. To allow students in the public health sector the opportunity to discuss the societal implications of tax-exempt debt financing.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case provides a opportunity for the student to consider, analyze, and discuss the possible use of a revenue-backed bond issue to finance capital construction by a state public health agency. The case deals with issues well beyond the fundamental financial analysis of the potential debt offering. These issues include political, ethical, and macro-environmental concerns. The analysis will require students to evaluate many different types of information, much of which is relevant, and some of which is not.

The case is based on the actual development of a bond issue for the construction of public health facilities in Alabama. All names and individuals are real and all financial data are the actual data complied and presented for the issuance of the bonds. The case ultimately places the student in the role of the state health officer, Dr. Donald E. Williamson. Dr. Williamson must make the final "go or no-go" decision on the sale of the bonds with the obligation to repay $30,000,000 of debt from future health service revenues. We have found it effective to ask students to work in groups. One student may play the role of Dr. Willimans, while others may act has his deputies and advisors.

The Alabama Department of Public Health (ALDPH) is somewhat unique. (See Appendix A -- "The Alabama Department of Public Health"). The system of state and local public health units is one of the largest providers of personal health services in Alabama. Most U.S. public health departments have a more limited role in direct patient care and receive only small amounts of fee income. ALDPH, on the other hand, is the largest provider of home health services in the state as well as well-child and other clinical services. A very significant amount of fee income, primarily from Medicaid and Medicare, is generated from these activities. In 1996, of the

department's $350 million budget, nearly $150 million came from reimbursement (fee generating) programs.

STRATEGIC ALTERNATIVES

1. Expansion/market development

2. Value adding service delivery – increasing access.

3. Value adding support – finance.

QUESTIONS FOR CLASS DISUCSSION

1. Summarize the main features of the bond issue and how the proceeds will be used.

The proceeds of the bond issue will be used for construction of county public health facilities. This is a tax-exempt revenue bond that is being sold for a term of 30 years. The issuer is the Alabama Public Health Care Authority, which is a public corporation, established by the State Committee of Public Health under the Health Care Authority Statutes of Alabama. The proposed bond issue includes a provision for repayment insurance.

2. What is the financial health of the Alabama Department of Public Health? How credit worthy is the Alabama Department of Public Health? What is the basis of the Departments ability to repay the bondholders?

The ALDPH appears to be very credit worthy. The annual debt repayment is less than 1 percent of the Department's annual revenues. The Departments budget has been growing. Repayment is based on revenues from services primarily to beneficiaries insured by federal and state programs.

The students may then be asked to discuss any other alternatives that the Department may have for financing the construction of new local public health facilities. Such alternatives may include government grants, philanthropic donations, joint ventures with county governments, or do nothing and continue to use existing facilities. Discussion of alternative methods can include the socio-political implications of each.

If it would be useful for the students to practice specific financial calculations, questions such as the following can be used:

3. Briefly discuss the difference between taxable and tax-exempt debt. How much is saved by issuing tax-exempt by the Alabama Public Health Department?

Interest earnings on the tax-exempt bond by the investors are exempt from federal income taxes but the earnings from taxable bonds are not. Not-for-profit institutions, including, government organization are eligible to issue tax-exempt bonds. Because of tax-exemptions of interest earning, the coupon rates are usually lower than the equivalent taxable bonds. The difference in interest rates between taxable and tax-exempt bonds of equal quality runs in the range of 200 basis points,

i.e., 2 percentage points. The present value of the amount of interest cost savings to the Alabama Department of Public Health is $6,209,307. The calculation is based on the discounted value of the opportunity cost of funds in each of the respective years. (See exhibit TN21-1)

Exhibit TN21-1 Calculation of Saving from Issuing Tax Exempt Debt

N	Year	Debt Outstanding	Additional Interest Cost for Equivalent Taxable Debt	Discount Rate	Discount Factor
0	1999	$30,000,000	$600,000		1.000
1	2000	29,505,000	590,100	0.07	0.9346
2	2001	28,975,000	579,500	0.07	0.8734
3	2002	28,405,000	568,100	0.07	0.8163
4	2003	27,795,000	555,900	0.07	0.7629
5	2004	27,145,000	542,900	0.07	0.7130
6	2005	26,450,000	529,000	0.056	0.7211
7	2006	25,715,000	514,300	0.052	0.7013
8	2007	24,940,000	498,800	0.053	0.6616
9	2008	24,125,000	482,500	0.054	0.6229
10	2009	23,265,000	465,300	0.055	0.5854
11	2010	22,360,000	447,200	0.06	0.5268
12	2011	21,400,000	428,000	0.06	0.4970
13	2012	20,380,000	407,600	0.06	0.4688
14	2013	19,300,000	386,000	0.06	0.4423
15	2014	18,155,000	363,100	0.06	0.4173
16	2015	16,945,000	338,900	0.06	0.3936
17	2016	15,660,000	313,200	0.06	0.3714
18	2017	14,300,000	286,000	0.06	0.3503
19	2018	12,855,000	257,100	0.06	0.3118
20	2019	11,325,000	226,500	0.06	0.3118
21	2020	9,700,000	194,000	0.06	0.2941
22	2021	7,980,000	195,000	0.06	0.2775
23	2022	6,155,000	123,000	0.06	0.2618
24	2023	4,220,000	84,400	0.06	0.2470
25	2024	2,170,000	43,400	0.06	0.2330
26	2025	0			

Total Savings = $ 6,209,307

4. Compute the average rate of interest for the proposed bond issue.

Amount	Interest Rate	Weight
$495,000	7.00%	0.0165
530,000	7.00	0.0177
570,000	7.0	0.0190
610,000	7.0	0.0203
650,000	7.0	0.0217
695,000	5.60	0.0232
735,000	5.20	0.0245
775,000	5.30	0.0258
815,000	5.40	0.0272
860,000	5.50	0.0287
10,410,000	6.00	0.3470
12,855,000	6.00	0.4285
30,000,000		

Weighted average rate of interest =
0.0165*7.00+0.0177*7.00+0.0190*7.00+…. +0.4295*6.00 = 6.01819%

5. Prepare an amortization schedule for the bond issue.

Suggested answer:

FY Ending Sept 30	Principal	Interest	Total Debt Service
1999	$0	$902,638	$ 902,638
2000	495,000	1,802,275	2,300,275
2001	530,000	1,770,625	2,300,625
2002	570,000	1,733,525	2,303,525
2003	610,000	1,693,625	2,303,625
2004	650,000	1,650,925	2,300,925
2005	695,000	1,605,425	2,300,425
2006	734,000	1,566,505	2,301,505
2007	775,000	1,528,285	2,303,285
2008	815,000	1,487,210	2,302,210
2009	860,000	1,443,200	2,303,200
2010	905,000	1,395,000	2,300,900
2011	960,000	1,341,600	2,301,600
2012	1,020,000	1,284,000	2,304,000
2013	1,080,000	1,222,800	2,302,800
2014	1,145,000	1,158,000	2,303,000
2015	1,210,000	1,089,300	2,299,300
2016	1,285,000	1,016,700	2,301,700
2017	1,360,000	939,600	2,299,600
2018	1,445,000	858,000	2,303,000
2019	1,530,000	771,300	2,301,300

2020	1,625,000	679,500	2,304,500
2021	1,720,000	582,000	2,302,000
2022	1,825,000	478,800	2,303,800
2023	1,935,000	369,300	2,304,300
2024	2,050,000	253,220	2,303,200
2025	2,170,000	130,200	2,300,200
Total	$30,000,000	$30,757,438	$60,757,438

6. How might the bond rating affect the cost of the issue? Evaluate the factors of bond default for the Public Health Department and to express an opinion as to what the rating (such as AAA, AA, etc.) of the proposed bond issue should be.

Moody, Standard & Poor and other rating agencies take into consideration both financial and non-financial factors of organizations issuing bonds for assigning a letter grade to indicate the default risk of the issue. The letter grade varies from AAA to BBB for investment grade bonds, AAA indicates the best quality bonds, and BBB indicated medium risk bonds. The interest rate for AAA rated bonds obviously is the lowest. The investors need to be compensated properly in the form of higher interest rate for taking risk in the lower grade bonds. The spread in interest rates between a AAA rated bond and a BBB rated bond usually runs in the range of 40 basis points (0.4 percentage points).

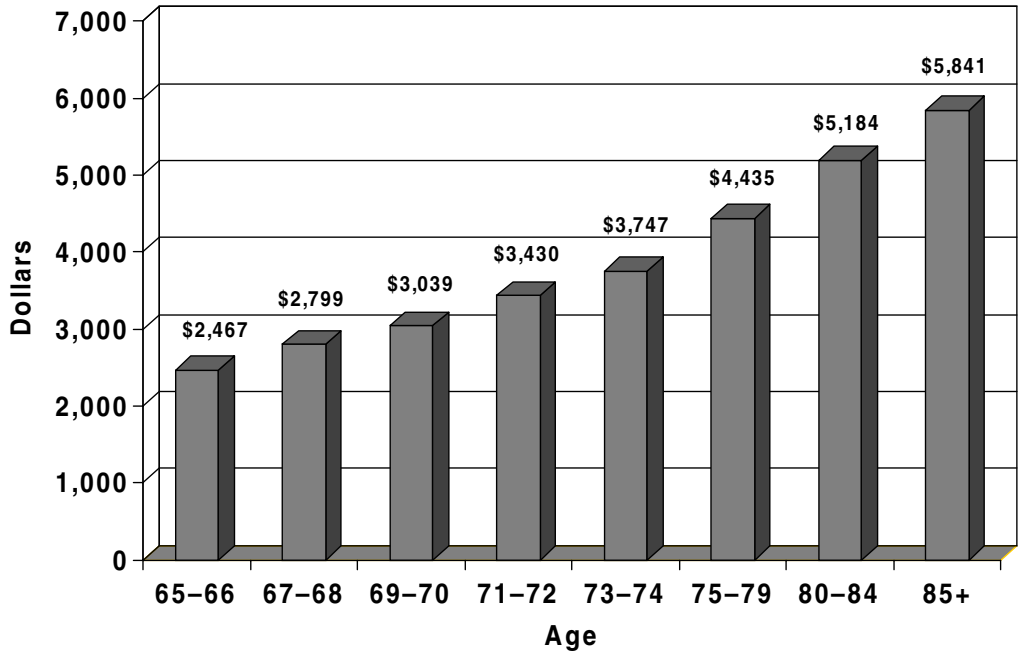
The important financial factors are: operating margin, cash flow, capital structure, guaranteed reimbursements, government guarantees and others. Non-financial factors include the reliability of the management team, efficiency, socio-political conditions and others. The Department budget shows a growth of over 6 percent a year with a budget of over $330 million in 1996. The average annual debt payment for the proposed new bond issue is $2.7 million, which is less than 1 percent. It appears the bond issue should receive a good rating.

7. What are the sources of revenue that may be available to repay debt. Discuss the health care trends that may influence the ability of the Department to repay the debt.

The sources could include government grants, reimbursements for services from Medicare and Medicaid, fee revenue from individuals receiving services from the Department, and others. The trends in the health care and socio-political environment that may impact these revenue streams might include:

- The aging of the population. The fastest growing age group in the population is individuals 85 and above. How will this impact Medicare and Medicaid? How soon are these impacts likely to occur? Individuals 85 and above are by far the most costly beneficiaries in terms of age groups in the population. This is not only true for therapeutic services provided through Medicare but also true for nursing home services paid through Medicaid. The largest single category of payment by Medicaid is for nursing home services.

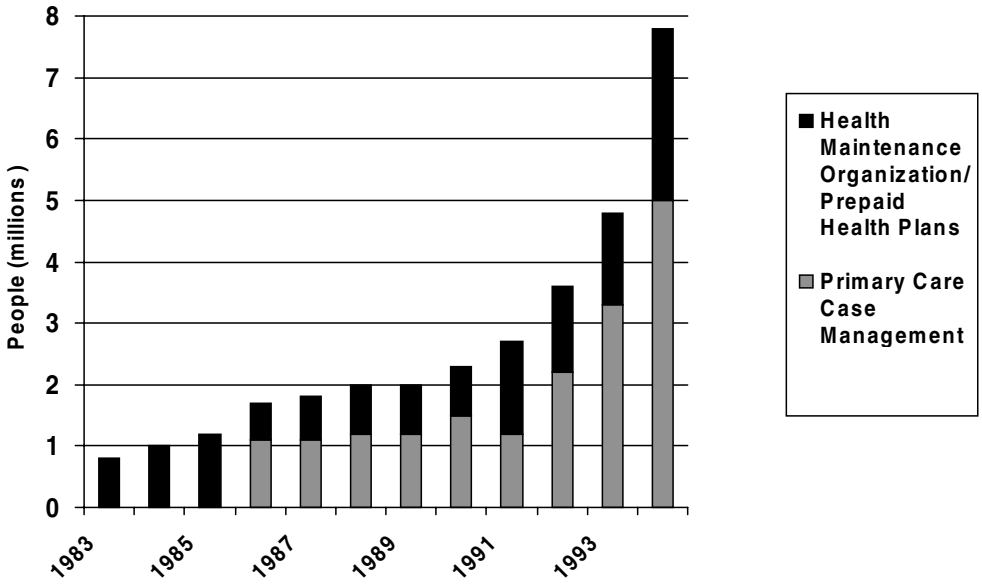
Medicare Payments per Enrollee, by age category - 1994



Source: National Center for Health Statistics, Health United States, 1994, Table 139, p. 244.

- The growth of "managed care." Experimentation by state Medicaid agencies with

Growth of Medicaid Managed Care Enrollment 1983-1994

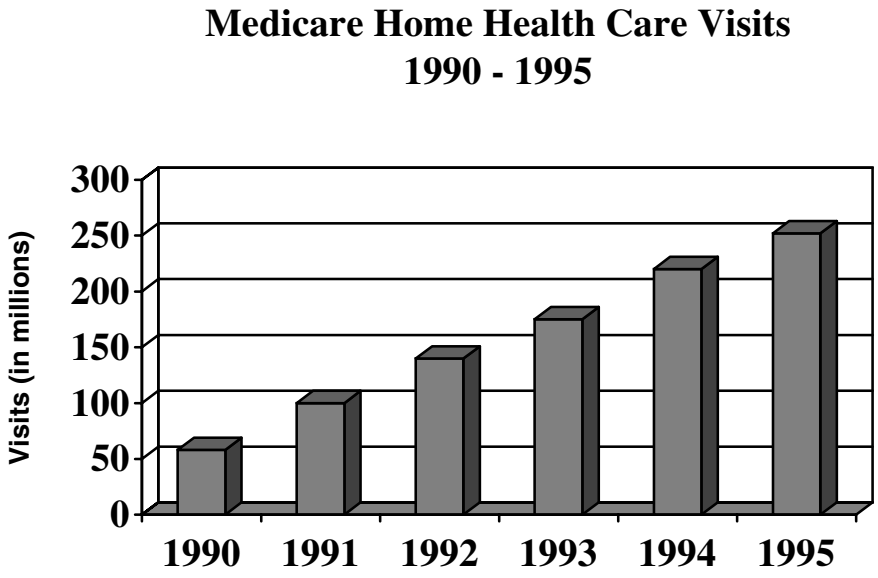


Source: National Conference of State Legislatures, "Medicaid Survival Kit, p. 8.2, 1996

various forms of managed care continues to grow. Medicare is increasingly moving beneficiaries to managed care arrangements. How may this trend impact reimbursement to the Public Health Department? At this point in time the payments to the Health Department from Medicaid and Medicare are still based on actual costs. Therefore, debt repayment can be included in the cost formula and

hence actually increase payments to the Department. Under a capitated payment system in a managed care arrangement, payments would be fixed regardless of costs.

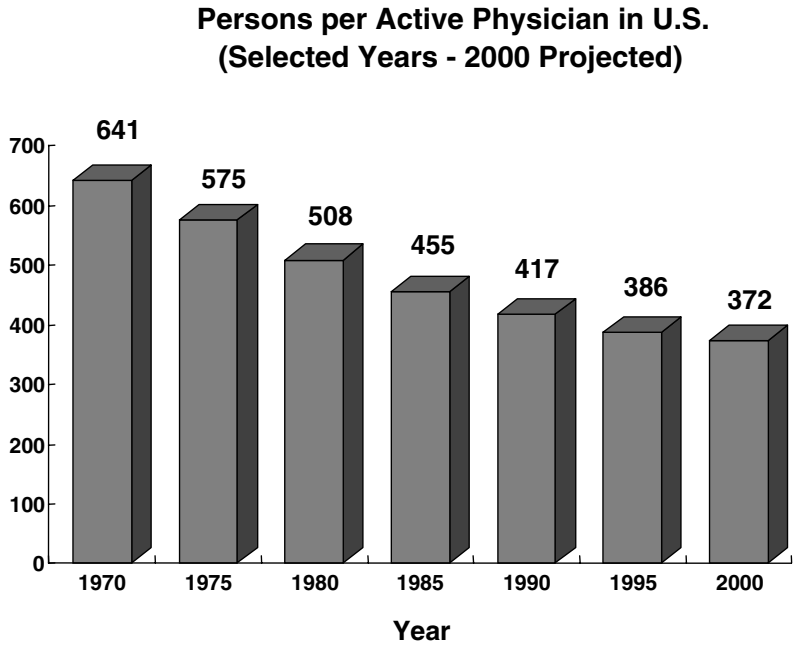
- Continuing growth in expenditures for home health services. Home health may continue to be an industry in transition. What are the likely transitions and how



Source: "Medicine & Health Perspectives," Faulkner & Gray

may the changes in this part of the health care industry impact the revenues of the Public Health Department?

- Increasingly supply of physicians. The population per active physician ratio will continue to decline for the foreseeable future. How will the increasing supply of physicians and the intentioned change in specialty mix influence the services of the Public Health Department?



Source: Adapted from National Center for Health Statistics, Health United States,

EPILOGUE

Dr. Williamson decided to proceed with the bond issue. The sale was highly successful. The market considered the issue to be of very high quality and the national bond evaluation services gave the issue their highest rating. Moody's rated the Health Departments bonds as "Aaa" and Standards and Poor's rated the bonds "AAA."

As of the end of May 1997, 25 of the county construction projects were underway. The construction was ten months ahead of schedule and was running approximately $500,000 under budget. Dr. Williamson was now considering going back to the debt markets to finance the second half of the county public health facility construction projects.

The Alabama Department of Public Health

The Department is an agency of the State created under State law and charged with the responsibility for enforcing the Stateís public health laws, exercising supervision and control over the county boards of health, and providing public health services to the residents of the State. State law also provides for the creation of the State Committee of Public Health (the ìState Co mmitteeî) w hich is organized as a 16 member board composed of 12 members of the board of censors of the Medical Association of the State and the chairmen of four councils (dental health, environmental health, disease prevention, and health cost and administration). The State Committee serves as the board of directors of the Department and appoints the State Health Officer, who serves as the Chief Executive Officer of the Department.

The State Health Officerís primary responsibility is to organize the Departmentís direct comprehensive public health programs. The State Committee establishes policies, rules, and regulations regarding public health. State and county health department activities are under the supervision of the State Health Officer. Donald E. Williamson, M.D. is the current State Health Officer and has served in that position since 1992.

The Department is one of the largest agencies of the State with over 6,200 employees and a budget exceeding $350 million in fiscal year 1996. The Department is a major, essential provider of clinical and home health services through a wide range of programs. It also provides regulatory and support ser vices. During fiscal year 1995, over 2 million clinic visits and services were provided. More than 1.7 million home health visits were made and over 1 million hours of services were provided to elderly and disabled patients. During fiscal year 1995, the Departmentís regulatory programs issued over 5,600 Emergency Medical Technician licenses, 867 health inspections of over 16,000 food establishments, and conducted over 5,800 solid waste inspections.

The Departmentís funds are derived each year from state and local appropriations and from payments by the federal government for services rendered through grants, contracts, and fees for health services to eligible patients. In fiscal year 1995, over 80 percent of the Departmentís total budget was attributable to funds derived from Medicare, Medicaid, contracts, and federal grants. Each of these programs contains costs reimbursement features allowing the Department to recoup its cost of providing services. The rental payments required of the Department under the Lease will be an allowable cost under such federal programs.

CASE 22

US HealthSolutions

Linda E. Swayne

OVERVIEW

US HealthSolutions (USHS) was a privately held company attempting to decide whether to offer a product that was not available elsewhere from a single provider. USHS planned to add value to: 1) the health care system by connecting the physician and the patient via Internet based data, providing faster physician access to medical records; 2) the corporate human resources programs by introducing electronic medical records, electronic universal data forms, Internet links to worker's compensation, and advance health care directives; and 3). the individual employees of companies through faster access to electronically controlled medical records that needed to be initiated one time and then simply updated, on-line worker's compensation forms to expedite the claim process, and quicker access to advance health directives to ensure that patients had ultimate control over resuscitative measures.

USHS's core service was to be hands-on education associated with advance directives provided as an employee benefit by employers. For the employee, the service offered unlimited logistical access to legally-executed advance directives, providing confidence that the employees wishes would be made known to caregivers. Periodic reminders to employees would keep medical records information up to date. Qualified clinicians were employed to glean only significant and necessary client medical record information; the company's employee was relieved of this responsibility. Companies that purchased the USHS product were provided management reports allowing them to monitor the effectiveness of the advance directive program both in terms of employee participation and cost savings.

A significant portion of the population (approximately 43 percent) had not been exposed to consultation concerning end-of-life care. Therefore, there was a large untapped "market" of potential customers. One-third of durable powers of attorney for health care and 35 percent of living wills were completed within the last week before death; often the patient's wishes were not carried out because there was insufficient time for processing. Approximately one-third of persons under age 55 had a living will. Few resources existed to promote the process of advance care planning. People tended to be reactive rather than proactive regarding end-of-life care. USHS planned to offer its service through educational seminars instructed by qualified professionals from the medical and legal communities who would provide customers with an in-depth understanding of advance directives, their intent, and the process of executing them.

The target market was companies that had 1,500 employees or more as they had the potential to generate a cost savings that would significantly impact the bottom line (based on the new accounting requirement SFAS #106) that severely impacted available cash. McKessonHBOC and Healtheon/WebMD were potential competitors in this market.

KEY ISSUES

1. New product offering for health care technology.

2. Difficulty of dealing with products that are related to death and dying.

3. Internet-based health care products are in a very competitive environment.

4. Strategic alliance versus internal venture.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Analyze data to project a profit or loss on a new product offering.

2. Develop a strategy for a start-up venture.

3. Determine whether to market the new product (service) or forego the new venture.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

Strengths	Weaknesses
Unique product	New product, no awareness
Completeness of the product offering – electronic data storage, advance directives, insurance forms, workers' comp forms	Heavy in technology and the market is less receptive to these products at this time
First mover competitive advantage	USHS is small, unknown, and needs capital
Under SFAS #106, the product offered huge savings for companies with a large number of employees and retirees	High operating costs because educational personnel must include physicians and attorneys
Educational component in delivery of the product to large company's employees	Heavy investment in training for electronic data handling
Management receives reports to monitor effectiveness of the product	No concrete evidence of cost savings: "spend now to save later"
ER MDs determine what to include in the patient record	Product deals with death and dying
Opportunities	Threats
Companies need ways to control rising health care costs	People are reactive not proactive over end-of-life care – they do not want to discuss it
Economic growth of the Sunbelt – many large companies moving there	Media attention on physician-assisted suicide may dissuade discussion of advance directives or health care power of attorney
On average, one employee carries two dependents on a company's health plan	Major players in the market (McKesson-HBOC, WebMD) have name recognition and relationships with large companies
One-third of those under 55 had a living will	Hospitals provide some record keeping and advance directive services at no change

STRATEGIC ALTERNATIVES

1. Expansion through Internal Development. USHS should hire its own sales force and call on customers with 1,500 employees or more in all parts of the United States.

2. Expansion through an Alliance. USHS can form an alliance with one or more major managed care organizations.

3. Expansion through a Joint Venture. USHS can partner with a managed care organization, sharing costs and profits.

4. Divestiture. USHS can sell off the idea for its product.

QUESTIONS FOR CLASS DISCUSSION

1. Does USHS's product meet its company goals?

   USHS has three corporate goals:

   - To add value to the health care system by connecting the physician and the patient via Internet-based data, providing faster physician access to medical records.
   - To add value to the corporate human resources programs by introducing electronic medical records, electronic Universal Data Forms, Internet links to worker's compensation, and advance health care directives.
   - To add value to the individual employees of the client companies through faster access to electronically controlled medical records (that needed to be initiated for first time use and then simply updated), on-line worker's compensation forms to expedite the claim process, and quicker access to advance health directives to ensure that the patient had the ultimate control over resuscitative measures.

The product, as conceived, does meet USHS corporate goals. The product offers benefits to the employee and his or her physician by making emergency data available through the Web enabling access at any time and nearly any place. Benefits are offered to customer companies in terms of availability of insurance forms and advance directives (that will save the company from having to place so much of its operating funds into accounts for retirees' health benefits). Employees of customer companies will benefit by having an electronic medical record for emergencies, on-line insurance forms, and a legally executed advance directive so that his or her wishes will be followed in terms of end-of-life care.

Note that the company does not have a financial goal at this juncture. Students can assume that the company would like to at least break-even at some designated time in the future. In actuality, the company did not know what it should set for a financial or sales goal, primarily because it did not have any idea of what

kind of funding it might achieve. Despite the uncertainties, USHS should set a sales goal as well as other financial objectives.

2. Are Jim Keister's assumptions realistic?

The number of employees that can be trained in a year by one training team is realistic – IF the salespeople can assure the sales over time. The 2 largest employers, the 11 smaller companies, or some combination of the 23 companies that have over 1,500 employees would represent enough employees to meet the first year objective. Given the savings for the company that Jim has computed, it seems reasonable that this objective could be met.

The companies on the list (Exhibit 22-3) might not represent companies that would be in the "average" of the actuarial tables. Banks, schools, and health care organizations have a greater proportion of younger people as employees (five of the six largest companies). The number of deaths at 518.1 per 100,000 is probably not realistic given the actual larger companies in Charlotte.

Ten percent turnover of employees is probably low given the number of young women who work in the largest employer companies.

The medical loss ratio appears to be based on realistic assumptions, especially because they are provided as a range. It would be attractive to a managed care organization. The important question: "Once they understand the product, do they need USHS?" should only be discussed at this point if the students bring it up.

Selling 1.1 million shares of stock for $1.1 million in capital is probably not realistic. Venture capital availability in 2002 is quite limited. Developing their own sales force requires additional capital. Ask students if they were a venture capitalist, would they provide funding for USHS? Ask them to support their viewpoint. The brightest students may bring up the easy duplication of the product / service offering. If they do not, the instructor should hold off till other questions have been raised and answered. If students do bring it up, a reply such as "Interesting . . . what do the rest of you think?" allows for more discussion.

3. What would be the projected cost for internal development of USHS's product? What would be a reasonable sales goal for the first year?

The sales goal should be determined first to provide guidance on the other decisions, primarily because it will determine the expenses and thus the amount of additional cpital required. Is it possible for USHS to target all large employers in the United States or should it start smaller by targeting just the Southeast or just Charlotte? How much capital could USHS raise to cover costs of an expanded market?

Costs would include (see Exhibits 22-6 and 22-11):

- Personnel costs for education (MD, attorney, paralegals, additional staff to handle 100 to 125 individuals).

- Sales force to call on large companies (those with more than 1,500 employees).
- Advertising to build awareness for the new product.
- Call center operation (24/7).
- Technical support staff (IT individuals for initial upload of forms, patient records, information, and subsequent updates of patient records).
- Informational packets for each seminar attendee.

4. What is the projected cost for a joint venture with a managed care organization? What would be a reasonable sales goal for the first year?

A different sales goal would probably be set if managed care organizations are targeted for a joint venture. Cost details are provided in Exhibit 22-7 and 22-12. Many of the costs will be the same, although there will not be a need for as large a sales force and the advertising expenses would be avoided.

5. Should USHS introduce its new product to the market? Which strategy – internal venture or alliance with a managed care organization – makes the most sense?

Students tend to focus on the cost/profit differences of the alternatives for entering the market as presented in the case. Allow them to provide the many reasons why one alternative is better than the other. When new ideas begin to wane, move to Question 6.

6. Does USHS offer a competitive advantage for companies with a large number of employees? For the employees?

No one else is currently offering a product similar to that being developed by USHS; however, others could offer a similar product and rather quickly if they are large enough and invest enough money to speed the process. Timing may be the most critical factor.

The educational component was not being offered by others. Can USHS provide the number of seminars, to the number of people in each one, efficiently enough to accomplish profitability? Exhibit 22-2 details the expectation concerning the number of employees that can be handled in a single seminar. The "staff" needs to include a physician and attorney (per advertised product advantages). The MD can provide an overview of the benefits of advance directives; the electronic, available ER-use patient record; insurance claim forms; worker's comp forms and information; and so on. The formal presentation can be supplemented by other less costly employees handling specific questions with individuals. For example, paralegals can discuss sample wills and advance directives with individuals, but the attorney will probably have to sign it (in most states) and it will need to be witnessed.

Can USHS deliver this educational component faster and less expensively than anyone else? For a time, they may be able to, but another company can copy the idea – it is not a sustainable competitive advantage. Placing insurance forms and worker's comp forms on a Web site can easily be done by others. Providing access to an edited

medical record for emergency purposes can be copied as any other organization can also hire an ER physicians to edit the data.

A call center operating seven days a week, 24 hours per day will be required as well. Can USHS manage this operation more effectively and efficiently than others?

It should become apparent to students that speed to market may be USHS's only competitive advantage and it may not be sustainable.

7. Does USHS have a first mover advantage?

Not really. First because it does not have the product to market as of the time of the end of the case. USHS's product has been tested one time with a governmental agency in South Carolina and achieved excellent numbers of employees executing advance directives (at 90 percent, far higher than the 57 percent found in other studies). There has been no formal "sale" of the product and no data to substantiate the cash flow improvement or the cost savings that USHS envisions as major selling points for the companies that purchase its product.

Second, there are two large, well-funded, and well-connected companies that have signaled that they will be offering a similar type product. McKessonHBOC, through iMcKesson, potentially has access to 25,000 drugstores, 6,500 physicians, 5,000 hospitals, and 10,000 nursing homes – all of which are current McKesson customers (and one would have to assume – satisfied customers).

Healtheon/WebMD was already offering some, but not all of the services that USHS planned to bundle together as its product. Importantly, WebMD offered its service over the Web at no charge (as of 2001) to develop relationships with physicians, insurors, and patients. Although its product was not as complete as that being offered by USHS, its no cost alternative would be attractive to many.

Either of these companies could enter with a competing product in a short period of time and eliminate any advantage that USHS might have.

8. Would you invest in USHS?

No. If USHS can convince a managed care company to pay them for the service they offer, go for it! We suspect there will be no takers in terms of paying at the rates suggested in the case and the MCOs can begin to offer the service themselves. USHS cannot patent or copyright their idea. They have to be first, do it better than anyone else, and try to enforce contracts to make any money with this service.