C A S E 9

Helicopter Emergency Medical Services at the Medical College of Georgia Hospital and Clinics

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OVERVIEW

The Medical College of Georgia Hospital and Clinics (MCG) is a tertiary care state supported hospital in the southern region of the United States. It is located in the moderately sized community of Augusta, Georgia (MSA of 450,000) that has a significant medical industry. MCG has been presented with a proposal by a competitor hospital to jointly fund a helicopter emergency medical (HEMS) system. The competitor hospital is an aggressive, state-of-the-art institution that formerly supported its own HEMS but canceled its contract with a vendor approximately one year prior to the submission of this proposal.

As the state's medical institution, with the belief that it should be the state's medical leader, MCG would first like to evaluate the costs and benefits associated with independently sponsoring an HEMS, as well as co-sponsorship with University Hospital. The Assistant Administrator is faced with multiple considerations. Should the HEMS be viewed as a separate product line independently supporting itself, or should it be viewed as a loss leader to increase inpatient admissions and physician referrals? Can the cost of the system be justified by the reduction in mortality resulting from helicopter transport or by the fact that the institution has an obligation to provide state-of-the-art care to its citizens?

Information concerning the community, competitive hospitals, Medical College of Georgia, and the helicopter emergency medical services industry is provided. The Assistant Administrator must balance financial, marketing, social, and political considerations when determining the most appropriate course of action for the institution.

KEY ISSUES

1. Putting an organization at-risk financially in order to improve competitively.

2. Ethics, egos, and cost containment considerations in health care decisions.

3. Opportunity for culture conflict in a joint venture.

4. Strategic implementation.

5. Strategic control – are the mission and strategy appropriate?

TEACHING OBJECTIVES

1. To present a clear-cut situation where students can be forced to make a decision.

2. To reinforce the importance of the mission/marketing/finance interface within strategic management.

3. To relate strategy to mission.

4. To apply financial analysis skills to decision making in a health care organization.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case concentrates on a decision concerning whether to independently or jointly fund a helicopter emergency medical service system. It provides the student with insights into the complexities of hospital decision-making. The student should recognize that although sound financial decision-making is important to all organizations, factors such as image, institutional mission, and others, weigh heavily in the process.

Providing the students have moderate financial analysis skills, this case can be used early in the semester to highlight the mission/strategy/finance issue. In addition, the case is useful early in the semester because it has a definite decision to be made. We have found that when students realize that the instructor expects a decision about what will be done tomorrow, they spend less time "hedging" and more time in analysis and justification. Subsequent case analyses are improved.

This case is good for role-playing. One student can be assigned to each of the following roles:

- Hospital Administrator
- Physician (from the hospital staff)
- Financial Director
- Marketing Director
- Community Representative (head of the volunteers, local religious leader, or whatever fits your community)

There is sufficient information in the case to allow each role to develop strong arguments for sponsoring or not sponsoring a HEMS and if the decision is made to sponsor the service, whether to enter into joint sponsorship.

With a larger class, various groups can be assigned the alternatives that are offered in the case:

- Do not sponsor HEMS
- Sponsor the HEMS with University Hospital
  - Loosely managed between the two hospitals
  - Develop a separate organization to operate the HEMS
- Sponsor the HEMS with another local hospital
- Sponsor the HEMS independently

Good arguments abound for each group generally resulting in lively debate. Medical ethics are almost always part of the discussion: "Can we afford to offer the HEMS? Can we afford not to offer the HEMS?"

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths	Weaknesses
1. State supported.	1. State supported.
2. Reputation and expertise in trauma care.	2. Financial situation.
3. Image.	3. Operating at capacity for trauma care.

Opportunities	Threats
1. Growth of the sun belt area.	1. University Hospital.
2. Consumer expectations are high for emergency care.	2. Tertiary-care image without HEMS.
3. Increase in cardiac care with aging population.	3. No change in Medicare/ Medicaid reimbursement practices.
	4. Third party payor coverage policies.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion/market development – differentiation positioning strategy.

2. Maintenance/enhancement – quality, efficiency.

3. Maintenance/status quo – do not participate in EMS.

Market Entry Strategies.

1. Internal Development – independent EMS.

2. Cooperation – alliance or joint venture for EMS.

QUESTIONS FOR CLASS DISCUSSION

1. Prepare a summary of the pertinent background information concerning operation of a helicopter emergency service.

When summarizing pertinent background information, the student should include at least the following components:

Cost. To date there are no programs that independently break-even. This should lead the student to ask several questions:

1. Is it legitimate to evaluate the system as an independent product line or should it be viewed as a loss leader?

2. Because reimbursement is on a case-by-case basis, is there sufficient data to reasonably forecast revenues?

3. Will Medicare and Medicaid continue to reimburse at the ground transportation rate or develop a more appropriate rate?

4. If cost sharing is determined by "usage" how will the institutions adjust for case mix variation? For example, two institutions could admit the same number of helicopter patients in a month; however, due to case mix variation (third-party payor vs. private pay vs. indigent care), one institution could generate significantly more revenue.

Analysis of this factor would suggest "NO" to establishing a HEMS.

Mission. As stated in the case, MCG's mission incorporates an orientation targeted toward the types of patients most often transported by helicopter; i.e., trauma/high intensity patients. As is true for most state supported hospitals, MCG desires to increase its percentage of self-pay patients. Will the helicopter system contribute to attracting more patients in this payment category? A response to this question requires an analysis of the marketing effectiveness of a HEMS which is discussed in Question 5.

Analysis of this factor seems to support a "YES" for some type of HEMS.

Occupancy Rate. Currently MCG's average occupancy rate for high intensity/trauma patients is 91 percent. Recognizing that admissions tend to run in "peaks and valleys," an occupancy rate this high will often lead to excess demand. If the HEMS results in "new captures" as indicated in the case, the institution does not have the current capacity to satisfy demand.

Analysis of this factor offers mixed results, as a HEMS would probably fill more beds, however the number of trauma beds is at capacity. Based on the current facilities, this factor warrants a "NO" to a HEMS.

Managerial. UH has a history of managing the HEMS and probably would like to continue to at least control key management positions. MCG on the other hand is the primary recipient of HEMS patients. These two conditions could lead to significant management problems, particularly if UH attempts to channel patients based on "ability to pay." A joint venture of this type would require the establishment of an independent management structure, which is at best difficult to accomplish. A subtle but important statement is made in the introduction: "UH coordinates the emergency care for Augusta and therefore currently controls which hospital emergency patients are sent to. . . ."

Analysis of this factor suggests "YES" to a HEMS.

Population Data. The student should recognize the relationship between population forecasts and the relevant range of a HEMS. Although MCG is the state's health care institution, the relevant geographic market for the HEMS is approximately 100 miles.

Analysis of projections of the population base indicate a "YES" to the HEMS.

Competition. Currently no local emergency helicopter service is being provided in Augusta. If the institutions do not jointly provide this service, is there a hospital within 100 miles of Augusta that will use a HEMS to penetrate the Augusta market? Data in the case is insufficient to answer this question; however, the student should make some competitive assumptions in order to do an effective analysis.

In order to be competitive, this analysis would yield a "YES" to HEMS.

Image. The case states that there are both positive and negative image projections associated with the HEMS. The major liability is the poor safety record of HEMS that could create much "bad press" as well as an unacceptable financial liability for MCG.

The image of MCG indicates a "YES" for HEMS.

A summary of the factors and analysis decision is provided in the table below.

FACTOR	DECISION
Cost	No
Mission	Yes
Occupancy Rate	No
Managerial	Yes
Population Data	Yes
Competition	Yes
Image	Yes

Analysis of the major factors involved indicate that the Medical College of Georgia should be involved in a helicopter emergency medical service providing that the cost situation will improve over time and the hospital anticipates the opportunity to expand the number of trauma beds.

2. Prepare a cost analysis for the helicopter emergency service for MCG.

The following summarizes the helicopter and hospital costs associated with the helicopter service. The literature consensus is that twin-engine helicopters are required for both safety and patient care considerations.

HEMS Cost Data, Medical College of Georgia

Helicopter Costs	Light Twin Engine	Medium Twin Engine
Purchase	$800,000	$1,500,00
Lease	$37,500/month	$56,000/month
Hourly Operation	$305/hour	$415/hour
Fuel	$50/hour	$50/hour

EXHIBIT TN9.1 Hospital Costs

Helipad		$10,000
Communications		1,000
Staffing		
3.5 FTE RN (5 @ .70 Time)	93,000	
3.5 FTE EMT	66,500	
1.0 FTE Secretary	13,500	
0.5 FTE Management	12,500	
		185,500
Fringe Benefits		46,375
Indirect Costs		46,375
Total Annual Hospital Costs		$289,250

EXHIBIT TN9.2 Per Flight Costs

	Light Twin Engine	Medium Twin Engine
Helicopter	$610[1]	$830[2]
Fuel[3]	100	100
Hospital[4]	637	637
	$1,347	$1,567

[1] $305 hourly cost X 2.00 (average flight time) = $610
[2] $415 hourly cost X 2.00 (average flight time) = $830
[3] Fuel per hour $50 X 2.00 (average flight time) = $100
[4] Total annual hospital costs = $289,250 = $637.11
flights in 1987 454

Numbers are developed from material in the case which states that Carebird had a 90 day trial of 2000 flight hours on 958 missions.

3. Using your cost analysis in Question 2, what level of demand would be required for MCG to break-even?

Benefits come in two forms, financial (revenue) and non-financial benefits. Revenue comes from two sources: revenue from helicopter services and revenue from new patients who would not have been admitted were it not for helicopter transport to the hospital.

Research indicates that reimbursement for helicopter flights would be in the range of $800 to $900 per flight, although there are a significant number of people who believe it would be markedly lower.

New patients could contribute considerably to hospital inpatient revenue. The average trauma patient stays fourteen days. Assuming that two new patients could be accommodated per month, and the contribution margin per patient is $228 per day, then the contribution for new patients per year would be:

$228 X 14 X 2 X 12 = $76,608

The $228 contribution margin is calculated as follows:

$800	charge per day
.66	percent collection ratio
528	amount collected
- 300	variable costs
$228	per day contribution margin

EXHIBIT TN9.3 HEMS Financial Summary

	Light	Medium
Annual Operating Costs	$(611,538)[1]	$(711,418)[2]
Revenue from Helicopter Services[3]	385,900	385,900
Revenue from New Patients[4]	76,608	76,608
Net Gain (Loss)	$(149,030)	$(248,910)

[1] $1,347 X 454 (from EXHIBIT TN 9.2)
[2] $1,567 X 454 (from EXHIBIT TN 9.2)
[3] $850 (average reimbursement) X 454
[4] $228 X 2 X 14 X 12

Assuming revenue from new patients could not be increased at a rate of two per month, the increase in income would have to come from more flights to make up the short fall. Exhibit TN9.4 depicts a reasonable view of the problem.

EXHIBIT TN9.4 Flights Needed to Cover Shortfall

	Light	Medium
Short Fall	$149,030	$248,910
Cost per Flight	1,347	1,567
Assume variable cost per flight: 20 percent	269	313
Contribution Margin (.80 X $850 average reimbursement)	680	680
Number of additional flights per year to cover shortfall	219	366
Assume variable cost per flight: 30 percent	404	470
Contribution Margin (.70 X $850 average reimbursement)	595	595
Number of additional flights per year to cover shortfall	250	418

Of course if the number of flights were increased, the average cost per flight would decline, as the fixed costs would be spread over more units. Ideally the fixed and variable cost components should be separated based on total costs and not on unit per flight costs.

4. What are the chances of MCG achieving break-even within the next five years? What other factors would enter into the analysis?

MCG would have to achieve a 48 percent (219/454) increase in flights based on a 20 percent variable cost factor and a 53 percent (250/454) increase based on 30 percent variable cost factor. This assumes the variables that produce a given contribution margin will stay the same. If one assumes a five percent compound growth rate of flights then it would take about 16 years. Given the growth characteristics of the Augusta area, a 10 percent growth rate is probably more appropriate. This means it would take about 8 years to break-even.

One non-quantitative factor that would facilitate initiating a HEMS program is improved patient outcomes. Studies have shown significant mortality decreases for helicopter transported trauma patients. Other possible benefits are name recognition and a positive image through association with lifesaving state-of-the-art health care. This assumes that a proper helicopter investment and safety-conscious operations will prevent accidents. As the state's medical institution, MCG may feel that it has a mandate to provide state-of-the-art health care. Projections by experts suggest that within the next decade HEMS will be as common for tertiary care providers with trauma capabilities as emergency rooms are today.

One of MCG's goals is to attract new self-pay patients. The HEMS may be a vehicle for accomplishing this goal. Frequently, rural trauma patients or patients

requiring high intensity services are admitted to rural local hospitals in an effort to stabilize them. These patients are then transferred (usually by air) to a tertiary institution. Should MCG participate in the HEMS venture it would probably increase its "captures" of these patients.

5. Comment on the marketing effectiveness of HEMS.

Hospitals frequently incur a significant expense to initiate HEMS under the assumption that it will be a strong promotional technique. This assumption is at best highly questionable and, more than likely, incorrect. At an average annual cost that exceeds $600,000 it is a very expensive promotion tool which is targeted to the wrong market. A HEMS will provide an institution with high visibility among the general population, but because the demand for hospital inpatient services is essentially derived demand via the physician, high visibility among the general population will probably have little impact on patient census. However, HEMS should contribute to an institution's prestige and status (image) impacting its socio-political position within the community which indirectly may have economic ramifications. However, the cost relative to this benefit is questionable.

The distribution component of the marketing mix may be greatly enhanced by HEMS. Frequently, patients transported by a helicopter are first admitted to small rural or suburban hospitals to be stabilized. The availability of HEMS often will dictate the referral pattern from one hospital to another. If a rural physician becomes familiar with a hospital through its HEMS capability, he or she will be more likely to refer other non-helicopter tertiary care patients to that institution. Therefore, the HEMS may be a vehicle for penetrating untapped markets.

MCG may not have any option but to participate in the program. Because it is the state's tertiary care institution, it cannot afford to be viewed as anything less than a state-of-the-art institution. Should UH initiate the service independently it would certainly project negatively on MCG.

6. What is your recommended course of action for MCG? Be specific in your answer.

Either course of action (pro or con) is certainly a viable alternative for the institution; however, in either case the student should recognize that financially it will be a loser. Should the student recommend a joint venture, the following should at least be included:

a. Compatible relationship of an HEMS to the hospital's mission.

b. Image projection.

c. Competitive disadvantage of not joint venturing.

d. Establishment of stronger referral patterns with rural physicians.

e. Recognition that there are expansion plans to accommodate an increase in intensive care patients.

Should the student recommend rejection of the program, the following should be included:

a. Because the hospital's goal is to increase paying patients, one might assume that the institution's financial position is marginal. Participation in an HEMS joint venture might create a financial burden the hospital is unable to handle.

b. Because the institution was receiving a majority of the helicopter patients, why incur an additional cost?

c. Currently, the institution's intensive care and trauma units are at capacity. An increase in patient census would over-burden the physical facilities.

d. With society's current concern for cost control within the health care industry, MCG should be able to generate some positive publicity by not participating in the program and saving the tax payers dollars!

7. Given your analysis and recommendation, why do you think there is a strong growth in helicopter ambulance services throughout the United States?

Most HEMS are operated by not-for-profit hospitals and city or county hospitals. It is important for the student to recognize that the management of a not-for-profit organization is different from managing a for-profit organization. It is an oversimplification to suggest that hospitals must become more "bottom line" oriented. Although most not-for-profit hospitals are very concerned with generating sufficient revenues to offset expenses, they also have multiple goals that are often incompatible. For example, MCG, as the state's tertiary care institution, has an obligation to do its best to improve the health status of the population. If the HEMS will in fact save lives that would have otherwise been lost, the system should at least be given serious consideration. Ideally, a cost/benefit analysis would provide data to support or reject this decision. However, cost/benefit analysis tends to ignore the "private motivations" of hospital decision making and a strategy which maximizes society's benefits may not be beneficial to a specific institution. The health care industry has been accused of having a Cadillac orientation and this accusation is probably accurate. However, historically, this preoccupation with high tech, high cost has been supported by society.

A status/prestige orientation is quite evident in the health care industry (just look at all of the people who want to wear white coats). An institution may want to incur the cost of an HEMS just to enhance its prestige within its relevant community.

Physicians are inclined to seek affiliations with hospitals that maintain state-of-the-art capability in their specialty area. One might easily argue that in order to recruit competent trauma physicians an institution would have to at least provide an HEMS capability.

C A S E 10

The Rosemont Behavioral Health Center

Phil Rutsohn and Bob Forget

OVERVIEW

Lloyd Lewis purchased The Rosemont for $1 million with funds from his brother, Cates Lewis. The Rosemont, a behavioral health center that was primarily an inpatient facility for the treatment of addictions, was in trouble. A member of the board called Cates to tell him there was insufficient cash to meet payroll. Because Lloyd had told him everything was "fine," Cates admitted that he had been "slack" as a board member. Cates arranged for a $3 million line of credit and began to investigate the problem; however, he had his own successful publishing company to run.

By the time Cates met Charles Brown, most of the $3 million line of credit had been used. Charles Brown, a health care consultant, agreed to make a two-day site visit to determine whether he could help The Rosemont. He recommended that two levels of intervention were needed: a comprehensive crisis management program to reduce costs and increase short term revenues and a long term strategic plan to position the organization for the future. Charles was hired with a nine-month contract at a cost of $25,000 per month. His first decision was to employ a turnaround specialist, Matthew Ibrahim, as a contract CEO. Matthew outlined the problems he uncovered in the first several weeks and informed Charles that there simply were not enough patients coming through the door to cover costs. Matthew suggested that marketing expertise was needed to help fill beds. A marketing firm was hired and performed a marketing audit. With so many possible alternatives, some significant undertakings and some rather simple, the student is to determine what should be done to turn The Rosemont around – if it can be done.

NOTE: This case is based on a real situation; however, the names of the organization, its location, and all players have been disguised. The financial data is accurate.

KEY ISSUES

1. A turnaround strategy for a health cares organization in financial distress.

2. Balancing short term fixes to keep the doors open versus longer-term strategic management.

3. External changes in this segment of the health care industry are threatening survival of many organizations.

4. An organization's structure impacts its ability to succeed.

5. Board selection, management, and responsibilities.

TEACHING OBJECTIVES

After analyzing this case the student should be able to:

1. Determine the break-even point for The Rosemont to decide whether a turnaround is possible.

2. Develop a list of short-term crisis management interventions.

3. Develop a strategy for The Rosemont to survive or decide to close it down.

4. Understand the advantages of a corporate board structure for a health care organization.

SUGGESTIONS FOR EFFECTIVE TEACHING

The Rosemont is not alone in its current crisis. Many behavioral health organizations are struggling. The keys to future success for psychiatric centers are outpatient services and expansion into multiple complementary services. The Rosemont must cut costs, provide needed services, improve its structure, and keep prices affordable in the local market.

We have found role playing to be very effective for this case. A meeting of the board can be "called" to decide whether or not to hire Charles Brown. His fees, in light of the dire financial straits of the organization, are high at $25,000 per month. His requirement that he be able to purchase into The Rosemont at 13 percent of ownership would make him the second largest shareholder (after Cates) and change the entire dynamics of the board. Several of Lloyd's buddies should vehemently be opposed to any changes. How the student role-plays Cates – the bully big brother, the successful businessman, the logical individual, and so on will depend on how the other students play their roles.

After the decision is made to hire Charles Brown's firm (everyone knows that there is only one conclusion because the financial situation is dire), the class should take a break and reconvene the board meeting approximately two months later when Charles is making his presentation about the changes that he recommends. One student could be "Charles" as he presents the short-term fixes and another could be asked to be "Charles" as he presents the strategic changes that must be made.

Another method is to hand a stick to a student and indicate that he or she is now "Charles." Charles then presents his recommendations until he has no more (or the student can be asked to present one recommendation) and then hands the stick off to another student who develops additional recommendations (or adds one more recommendation). If the class is large, having a student present a single recommendation allows for greater participation.

Alternatively, this case works well as an exam case. Specific questions, such as those in the next section, can be asked of students when the time for the exam is short or they can merely be assigned to analyze the case.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

The following internal strengths and weaknesses and external opportunities and threats have been identified for The Rosemont.

Strengths	Weaknesses
1. Adolescent treatment at Bay Saint Louis	1. Cash flow is non-existent
2. Lloyd Lewis's experience as a counselor	2. Incompatible computer systems
3. Buildings could be modified to double the number of patients	3. Patient mix is 90 percent Medicaid / Medicare
4. Value of the fixed assets	4. Incompetent managerial employees
5. Knowledge of the trends impacting mental health and substance abuse	5. Focus on inpatient treatment when outpatient care is growing
6. Medical director of Rosemont – Jackson	6. Informal, reactive marketing efforts
	7. Low employee morale
	8. Pay-scale below community norms
Opportunities	**Threats**
1. Alcohol and drug abuse continues	1. Bank foreclosure
2. The frantic pace of life	2. Drop in demand for psychiatric services
3. Impact of economic downturns	3. Declining lengths of stay
4. Outpatient treatments	4. Loss of Medicare/Medicaid certification
5. Companies have determined that substance abuse treatment costs less than lost productivity	5. Managed care deletes behavioral health coverage

STRATEGIC ALTERNATIVES

1. Contraction / divestiture – Would one of the national chains be interested in buying any part of The Rosemont? Would the local hospital? The community would have to be strategically located for a particular behavioral health chain to be interested in The Rosemont. Certainly they would not be interested in paying $4 million (Cates's investment).

2. Contraction / liquidation – The Rosemont owes $4 million and its assets are $2.5 million meaning that Cates Lewis will lose $1.5 million.

3. Combination strategy – contraction/retrenchment followed by maintenance/ enhancement.

4. Combination strategy – contraction/retrenchment followed by expansion/product development.

QUESTIONS FOR CLASS DISCUSSION

1. Exactly how dire is the situation for The Rosemont?

The best students will use data from the case and determine a break-even number of patients per month to compare against the actual number of patients staying at The Rosemont per month.

The Rosemont is currently operating at 20 – 25 percent occupancy. Because of the limited, questionable, and poorly organized financial data, students will have to make some assumptions. However they should be able to generate a break-even analysis somewhat like the following.

The Rosemont's current approximate monthly fixed costs include:

Corporate management	$50,000
Management at each of the facilities	100,000
Interest-only payments on debt	30,000
Contract payment to TM (Charles Brown)	25,000
Other fixed costs including: insurance, taxes, other support personnel, automobiles, etc.	95,000
Total monthly fixed costs	$300,000

The average reimbursement rate for each patient day at either of the facilities is $250.

After subtracting the variable costs that are currently 40 percent, The Rosemont has a unit contribution from each of these reimbursed patient days of $150.

By dividing The Rosemont's monthly fixed costs ($300,000) by its average unit contribution margin ($150), a monthly break even of approximately 2,000 patient days is calculated.

The Rosemont has a total of 4,500 patient days available (150 beds x 30 days) each month. Dividing the break-even patient days of 2,000 by our available patient days of 4,500 indicates that The Rosemont has to operate its facilities at approximately 44 percent occupancy to break even.

Because the Rosemont is operating at 20 – 25 percent occupancy and has been for some time and needs to be at 44 percent to simply break even, it is definitely on the verge of bankruptcy. The 20 – 25 percent occupancy is an intolerable figure based on the organization's current level of fixed costs. The organization must reduce costs and increase its patient days to survive.

2. What short-term "fixes" should be implemented immediately at The Rosemont?

Because cash flow is non-existent, the first issue that must be addressed is cost cutting. However, cutting costs alone will not enable The Rosemont to survive. It needs more patients as well. Students normally come up with a number of cost-cutting activities that should be done immediately. At the very minimum, $60,000 per month has to be eliminated to have revenues equal expenses.

Short-term Cost Containing Fixes

- Restructure management personnel and close the corporate offices.

- Reduce administrative staff (currently enough staff for full occupancy when the occupancy rate is 20 to 25 percent).

- Maintain one chief of nursing for both facilities.

- Aggressively collect and factor accounts receivable. Accounts receivable are noted in the case as being high. The computer system went down and in fact was not operational for several months. By the time the computer system was up and running, patients had not been billed for six months. Therefore non-delinquent accounts were six months old! No telling how old the delinquent accounts were. Management should immediately sell the accounts receivable for whatever can be obtained (called factoring accounts receivable). It will probably not be much but still better than what they currently have. This expensive mistake is a write-off and anything will be better than nothing. Factors pay based on the "age" of the delinquent accounts and the likelihood of collection.

- Have the competent Jackson facility comptroller take over that position for Bay Saint Louis as well.

- Update and re-negotiate managed care contracts. As indicated earlier, there are a significant number of managed care contracts between The Rosemont's various payors, however many of these are out of date. In addition, the pricing structure needs to be evaluated for each contract. One full time position may be allocated to establish contacts, communication, and contract negotiations with managed care providers.

- Immediately begin keeping and analyzing financial data for each facility separately.

- Immediately stop paying on the lease car of the previous CFO (at minimum it will cut the insurance and maintenance costs even if it is parked until the lease is up).

- Immediately validate lengths of stay with insurors to determine patient coverage before admission.

- Immediately develop and implement uniform policies for petty cash, accounts payable, and purchasing.

- Immediately investigate consolidation of the various telephone systems and as soon as contractually feasible, act to cut costs.

- Immediately cancel cell phones or at a minimum implement a policy of no personal calls.

Short-term Revenue Generating Fixes

- Train employees to close the sale. The Rosemont has no idea how many patients are "lost" because there are no records of the number of potential patients calling in matched with how many actually show up at the door. The key phrase here is "showed up at the door." There was no effort made by the telephone operators to "make the sale" by motivating the person to come in right at that moment or for The Rosemont to go out and pick up the individual. There should have been a formal procedure established to ask the patient if he or she had transportation to the facility, when they could be expected to arrive, etc. If the individual did not have arrangements, then Rosemont personnel should be dispatched to transport him or her to the facility.

- Organize the marketing people to do marketing. Although there are positions identified for marketing there are no clear guidelines for authority, responsibility, and accountability. With a clear delineation through comprehensive job descriptions and specifications, the efficiency and effectiveness of the marketing personnel could be enhanced significantly. Specific responsibility for everything from mass media advertising to public relations to referral development must be identified and tasks assigned to specific positions.

  For each position, time allocation and expected outcomes must be identified. Currently, marketing activities by operating personnel are accomplished on an "as time permits" basis. The management problems associated with this orientation are obvious.

  Although there is no funding for marketing studies at this time, there are nonetheless some things that can and must be done. An important first step is to determine the current patient base. Expanding the number of patients is very difficult if marketers do not know who the current customers are.
  - Where do patients come from? Patients' zip codes can be determined from admission forms or billing statements. Normally this information could be accessed by computer, but given that the computer systems are incompatible, students should surmise that it is unlikely that this task can be done electronically. However, at the current low occupancy rate, it cannot be that big of a task to track down the zip codes.
  - Who refers the patients? If this information has not been collected at admission, it must be initiated as standard policy immediately. For those patients whose admission data includes the referral, a list should be developed of those physicians, therapists, and independent marketing contractors (IMCs) that have referred to The Rosemont most frequently. Visits should be made to encourage them to continue to refer to The Rosemont. Data could be collected during these visits about the additional needs of the referral source for other patients that they might not have recommended for The Rosemont.

- What do the patients come for? Specific treatments used and those desired but not available at The Rosemont should be collected into a report for future decision making.
- How long do they stay? Length of stay is important information for reimbursement as well as outcomes measures. Gone are the days when insurors paid for a month's stay for alcohol abuse or drug addiction. If a long stay is truly required and The Rosemont is performing this community service without sufficient compensation, then external fund raising should be considered.
- What is the collection experience with each? Payment methods and delinquencies must be brought up-to-date and used in decision making in the future. Some patients should not be "encouraged" to stay at The Rosemont.

- Establish a line item budget for marketing. Personnel costs are identified for marketing but other costs (advertising, etc.) are homogenized under a variety of account titles. There should be an identification of resources for advertising (mass media), referral development, personal selling, and so on. To evaluate performance and effectiveness, the organization must be able to identify where funds are flowing and specific outcomes associated with this flow of funds.

- Develop an assessment tool for evaluating independent marketing contractors. The Jackson facility has made effective use of independent marketing contractors (IMCs). These firms represent an excellent opportunity for outsourcing the responsibility for inpatient referrals. The organization should ensure that each IMC is reputable and is channeling only those patients to The Rosemont who can truly benefit from its services. The development of assessment criteria for entering into a partnering relationship with IMCs will reduce the risk of becoming involved with body snatchers. Limited information inhibits a comprehensive analysis of current contract arrangements with IMCs, but it appears (based on a global break-even analysis) that the Jackson facility is doing an effective job of negotiating financial agreements with IMCs.

  The IMCs who currently provide inpatient referrals do not appear to be making outpatient referrals. Unless there is a statutory reason for this, the policy should be changed to enhance the outpatient business as well.

3. What strategies are available to The Rosemont?

Once costs have been cut and cash flow re-established (the contraction strategy), then various maintenance of scope and expansion of scope strategies can be undertaken. A number of alternatives exist.

Maintenance of Scope / Enhancement Strategies

- Develop a comprehensive marketing plan. The organization must reduce to writing its distinct competencies/expertise, how it is perceived in the market, the competition, what the current patient base is, and where the market is going. From this type of information, strategies need to be developed that will not only stimulate current demand, but also strategically position the organization for the future.

- Restructure the organization. The organization is not sufficiently large to warrant a headquarters staff and an operating staff. Jobs need to be consolidated for top-level positions, reducing the high cost of management.

- Renovate the Jackson facility and identify potential new locations for the Bay Saint Louis facility. Although the lobby and other common areas at the Jackson facility present a positive quality image to potential patients and payors, patient rooms, hallways and the like are in need of significant renovation. At a minimum, the facilities need to be upgraded in such a way that they at least meet the minimum standards for Medicare. It is not likely that the organization would be able to classify space as "office" if patients are using it. Assuming that cash flow can be increased in the immediate future, major renovations need to be on the distant horizon.

  The Bay Saint Louis facility potentially could become an outstanding facility with considerable historic value; however, the cost of renovation would be extremely high demanding a significant increase in its prices. A more viable alternative to the organization would be to identify an alternative location.

- Develop criteria for evaluating satellite ambulatory programs. Market development and market penetration strategies for satellite programs appear to have been intuitively determined. Although intuition may have resulted in the best geographic selection and the best penetration strategies there is no evidence that an organized evaluation has been done. With a change in marketing strategies, could patient demand be increased substantially in each market? Or is the market potential limited? Is the Company maximizing its return for each of these programs? Without criteria and comparative data it is difficult for management to address these questions.

- Consolidate the computer and accounting systems.

- The Rosemont needs to perform an internal analysis – an objective assessment of itself. The following questions need to be answered:

  What is The Rosemont's real expertise?
  What are its distinct competencies?
  What is its perception in the market? In the community?
  Who are the direct competitors for The Rosemont? The indirect competitors?
  What programs are needed in each of their markets?
  Can patient needs be satisfied in ways that are different from current operations?
  Can The Rosemont modify what it is doing to target new and different patients?

Expansion of Scope / Product Development Strategies

- Develop outpatient (ambulatory) substance abuse care as a distinct product. As it has become for most health care, ambulatory care is the growth market for

substance abuse and mental health in general. The competition for inpatient admissions will continue to increase as the patient base becomes smaller and smaller it will become imperative to project the right image to payors. Although "packaging" does not determine quality care, the lack of appropriate packaging inhibits the perception of quality. Until the Rosemont has funds to renovate the Jackson or Bay Saint Louis facilities, priority should be given to initiating a strong outpatient program immediately. This program will improve cash flow and provide a financial base for renovations.

The organization has an opportunity to develop a distinct competency in this area and should aggressively pursue the strategy. Because the facilities available do not appear to be conducive to attracting insured patients, consideration should be given to off-site locations for the program. The target market for the program should incorporate two segments of the population in the immediate future: comprehensively insured middle income individuals and professionals who would benefit from participating in a program with cohorts.

- Increase marketing efforts in Bay Saint Louis to capture the adolescent market. Rosemont – Bay Saint Louis is identified in the community as an excellent program for adolescents. Adolescent care provides an opportunity for the organization to develop a distinct competency not only in the immediate area, but also potentially throughout the state and region. Adolescent care should not be limited to programs funded by state and local governments but rather should incorporate a comprehensive market to include managed care contracts, direct contracting, and insurance companies. A significant increase in mass media, personal selling, public relations, and referral development targeted toward the adolescent market was needed to enhance this market (product development) or for new locations around the state (market development).

- Develop and initiate an employee assistance program. A comprehensive program focused on a holistic approach to substance abuse and mental health should be developed and marketed primarily to mid- and small-size businesses. As a new product for The Rosemont, an employee assistance program (EAP) would require resources and a plan. The number of mid- and small size companies in the area, the number of competitors, and the amount of capital available to support the new product will determine whether this is a viable alternative.

4. What would you recommend to Cates about The Rosemont board of directors?

Some of the board activities border on the illegal; certainly they are not ethical. Specifically, the accounting firm that did the annual audit of the organization has two principals sitting on The Rosemont board – not exactly an arms-length relationship.

Board members apparently were selected by Lloyd based on their golfing game. Particular areas of expertise that would be expected of a corporate-type board did not occur. Neither was the board really a community-type board as the members were not noteworthy in their fund raising nor were they donating large sums to The Rosemont. It appears as though no one on the board was being fiscally responsible

(including Cates whom we would expect more from as he ran a successful publishing company).

EPILOGUE

The Rosemont still exists, but it is hanging on by a thread. The crisis management team improved cash flow sufficiently to keep the organization afloat. Things that were done immediately include:

- Wrote-off every dollar in accounts receivable,
- Closed the corporate offices relocating them to the Jackson facility,
- Eliminated any personnel not performing to the organization's expectations,
- One director of nursing handled both facilities,
- Negotiate with IMC agents to direct more patients to the facilities, and
- Telephone operators were trained to be more proactive and literally send transportation to immediately pick-up troubled clients who called and brought them to The Rosemont.

The Rosemont has yet to implement any strategic plan and it is rumored that the board composition changed. Charles Brown did not exercise his option to buy 13 percent of The Rosemont.

C A S E 11

HMA and Its Riverview Regional Medical Center Facility

Beth Woodard, Donna J. Slovensky, and Woodrow D. Richardson

OVERVIEW

Riverview Regional Medical Center (RRMC) was a 281-licensed bed inpatient facility located in Gadsden, Alabama. RRMC essentially shared the immediate service area with only one other facility – Gadsden Regional Medical Center (GRMC) – also an investor-owned facility. GRMC operated approximately the same number of beds as RRMC, but admitted about twice as many inpatients, and staffed a much higher FTE/bed ratio (4 FTEs/bed compared to RRMCs 2.5 FTEs/bed). In addition, outpatient visits for GRMC were much higher than for RRMC – 139,000 compared to 44,000.

Gadsden was approximately sixty miles from Birmingham via Interstate 59. The Birmingham regional metropolitan area incorporated more than twenty hospitals including the University of Alabama at Birmingham (UAB) Hospital and several nationally renowned specialty facilities. Out migration was therefore a significant issue.

RRMC, formerly owned and operated by an order of Catholic nuns, was approximately five years post-acquisition by Health Management Associates (HMA), a proprietary chain based in Naples, Florida. Operational turn-around at RRMC under the direction of Mr. Jon Vollmer had been successful. Subsequently, Mr. Vollmer was promoted to corporate vice president for operations in 1995, and was assigned responsibility for seven hospitals in five states. However, his replacement at RRMC resigned in June 1996. Mr. Vollmer agreed to act as interim executive director (as well as his operations position) until a satisfactory candidate could be recruited. The incoming executive director would face strategic issues relative to protecting and increasing market share.

KEY ISSUES

1. Responding to a turbulent health care environment that mandates alternatives to traditional inpatient services as a major source of revenue.

2. Creating a market niche in a limited geographic area with a declining population base where the primary competitor has twice the market share and is better staffed.

3. Very strong competition because out migration provides access to advanced high-technology services.

4. Problems that occur when a new acquisition in a corporate chain does not follow the corporate strategy and differs from other holdings relative to competition and market area demographics.

5. What to do when a key competitor is purchased by a major for-profit chain and thus has extensive corporate resources in addition to the previous advantages of organizational resources and market share.

TEACHING OBJECTIVES

1. To facilitate identification and discussion of current and emerging environmental issues which will impact health care organizations.

2. To stimulate discussion of alternative growth strategies that can be applied to a health care organization that is not the leader in its service area.

3. To develop strategies for the challenger in a service area to survive and grow.

SUGGESTIONS FOR EFFECTIVE TEACHING

Although some general references are made to trends and issues in the health care environment, this case lacks an adequate foundation for analysis within the context of the health care industry. If students have not had sufficient health administration preparation (either academically or experientially), the case should be preceded by appropriate lecture, discussion or other pedagogy to provide the necessary foundation.

Case analysis may be focused on the strategic alternatives available to RRMC. Students should be encouraged to develop a TOWS matrix prior to responding to the questions posed at the conclusion of the case. There are no "correct" answers to the questions. They are intended to stimulate discussion of alternative courses of action. For some questions, the options posed will be limited only by the student's creativity and willingness to investigate alternative modes for delivery of health care services.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths	Weaknesses
1. Affiliation with a financially stable, successful parent corporation with demonstrated entrepreneurial skills.	1. Potential image problems associated with cost-leader marketing and plush amenities (example of monogrammed towels).
2. Proprietary management information system and network.	2. Shared medical staff is not conducive to securing physician loyalty.
3. Expertise in improving billing, collections, and productivity.	3. Medical staff is resistant to developing new provider relationships.
4. Medical staff and clinical service structure is conducive to full-service health care.	4. Physician practices are physically separated from the hospital; GRMC physicians lease space in its on-campus

5. Shared staff (with GRMC) prevents competing hospital from achieving major clinical advantage.
6. The facility has been renovated to include state-of-the-art technology and it has excess capacity.
7. Experience in implementing innovative patient-oriented programs.

Opportunities

1. Increasing demand for lower cost health services.
2. Trend toward simple, comprehensive, direct arrangements between providers and consumers.
3. Low managed-care penetration in the market service area and the region in general.
4. Local economy is manufacturing based.
5. Gadsden is the largest health care center for three adjacent counties.
6. Small group practices often lack the administrative and management expertise and material resources necessary to improve efficiency.

professional office building.

5. Management information systems do not provide a total solution to business problems.

Threats

1. Aggressive competition from GRMC.
2. Out migration of potential patients to Birmingham health care market.
3. Declining population in Etowah County.
4. Increased regulation of all health care services.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion/market development – The corporate office (HMA) has been pursuing this strategy through market entry/acquisitions. Growth or maintenance of scope as strategic decisions after "turnaround" were decentralized to the individual administrative teams.

2. Expansion/market penetration – Attracting patients (in the historical service area) who currently use GRMC or travel to Birmingham as well as those with unmet health needs.

3. Expansion/market development – Extend the primary market area to include adjacent Cherokee and DeKalb counties.

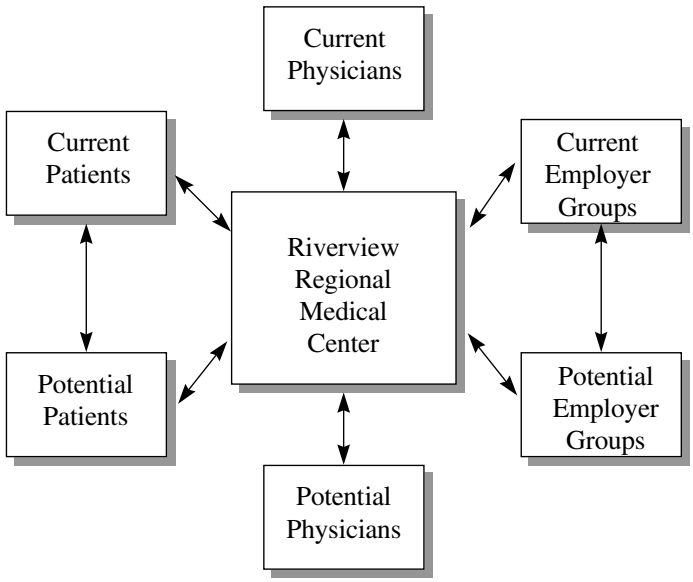
4. Expansion/product development – Develop an industrial medicine program to tap the manufacturing base of Etowah county.

5. Maintenance/enhancement – Better serve the current patient population by strengthening the network of service relationships in order to fend off threats of encroachment.

QUESTIONS FOR CLASS DISCUSSION

1. Construct a simple stakeholder map for Riverview Regional Medical Center. Discuss the target markets of existing programs and identify gaps in RRMC's marketing strategy.

EXHIBIT TN 11.1 Stakeholder Map for Riverview Regional Medical Center



The One Call Scheduling program is targeted at physicians and group practices. Students should recognize that a conference call approach is cumbersome, and is not likely to be efficient for a larger number of admitting physicians. The hospital should be investigating centralized resource scheduling applications software to enhance this strategy.

The MedKey program is targeted at employers and patients. However, the patients seem to be the primary recipients of membership perks associated with the program. Area merchants benefit from the affiliation by gaining name recognition. Benefits to employer groups may need to be reconsidered to strengthen the number of group members in the program.

The Nurse First program is targeted at patients. This program emphasizes immediate access to needed treatment before administrative processing occurs.

RRMC appears to have prioritized physicians and patients as its key stakeholders. Possibly, the CEO should consider changes in the relative power of employers and employer coalitions in his stakeholder management strategies.

Note: If students need introductory information about stakeholders, stakeholder maps, and stakeholder management strategies, we suggest Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders by John D. Blair and Myron D. Fottler (Jossey-Bass, 1990).

2. Develop a TOWS matrix for Riverview Regional Medical Center. What strategic alternatives are suggested by the matrix?

A TOWS matrix provides a conceptually simple mechanism to investigate strategic alternatives. The matrix summarizes an organization's internal strengths and weaknesses on the horizontal axis and its external opportunities and threats on the vertical axis. The format provides easy visualization for comparison of strengths with opportunities and threats, and weaknesses with opportunities and threats. Interactions among the four sets of variables suggest strategic alternatives.

EXHIBIT TN 11.2 TOWS for Riverview Regional Medical Center

	Internal Strengths 1. Corporate financial strength and entrepreneurial skills. 2. Management info system. 3. Expertise in productivity improvement and operations 4. Full service medical staff. 5. Shared medical staff prohibits clinical advantage. 6. Physical plant has excess capacity. 7. Innovative patient-oriented programs.	**Internal Weaknesses** 1. Potentially conflicting images with regard to cost control. 2. Shared medical staff not conducive to developing physician loyalty. 3. Medical staff is resistant to PPO, PHO, and other provider relationships. 4. Physician practices are geographically separated from RRMC. 5. MIS does not provide total business solutions.
External Opportunities 1. Employers need lower cost health benefits. 2. Trend toward direct provider-consumer arrangements. 3. Low managed care penetration. 4. Industrial economy; however no industrial medicine programs exist. 5. Etowah is the largest	Future Quadrant: <u>Market Development</u> • Use MedKey to establish links with local businesses • Market to adjacent counties • Market to businesses more aggressively <u>Related Diversification</u> • Industrial medicine; work	Internal Fix-it Quadrant: <u>Product Development</u> • Market the "patient-oriented" concept evident in Nurse First, MedKey • Investigate information system-based business solutions <u>Enhancement</u> • Shared administrative

health care center for three adjacent counties. 6. Physician practices may lack expertise/resources to survive administrative demands of managed care.	hardening program • Cardiac rehabilitation conditioning; fitness center • Outpatient therapy programs • Outpatient diagnostic services • Home care programs	services with medical staff as integrating mechanism • Consider information system linkages with medical staff office systems
External Threats 1. Competition from GRMC. 2. Out migration to Birmingham. 3. Declining population. 4. Increasing regulation.	External Fix-it Quadrant: <u>Enhancement</u> • Assure quality services	Survival Quadrant: <u>Market Development</u> • Promote "either facility – same physician" in marketing strategy • Investigate out migration patterns and target services where competition is both desirable and feasible

Source: TOWS matrix format modeled by Heinz Weihrich, "The TOWS Matrix: A Tool for Situational Analysis," *Long Range Planning* 15, no. 2 (1982), p. 60, with permission from Excerpta Medica Inc.

3. What new services or products could be developed with existing resources?

Industrial medicine services. These services include treatment for work-related illness or injury, physical examinations, safety education, and drug screening.

Work hardening program. Patients are referred to the program following Worker's Compensation claims. These programs typically employ physical and occupational therapists.

Sick child day care. This might present an opportunity to exploit currently unused space and existing resources toward the objective of expanding pediatric services. Health department regulations for day care providers would have to be investigated, but the essential resources are empty beds, nutritional support, and supervision. This program should be viewed as a feeder program that creates community goodwill rather than a serious source of revenue.

4. What services need to be strengthened and promoted to control out migration from the primary service area?

No "quick fix" answer exists for this question. The student should identify information needs and potential sources of information necessary to formulate a strategy. First, Mr. Vollmer should identify services where growth is both desirable and feasible — those where physical resources and staff currently exist or can be readily acquired. Second, knowledge of existing out migration volume and patterns for the identified

services must be determined. Third, data should be reviewed to determine whether services equivalent to those provided in the Birmingham facilities are available at RRMC. Information analysis should suggest two questions: "Does RRMC want to develop services not currently available in order to compete with Birmingham providers?" and "Does RRMC want to promote the identified existing services as desirable alternatives to Birmingham providers?" Answers to these questions are necessary prior to formulating a strategy to control out migration.

5. How can the Emergency Department resources be better utilized?

A number of possibilities exist for RRMC, including:

- Contracts with local employers for physical examinations, drug screening, and others.
- Low-cost health screening for individuals or businesses, perhaps through Med-Key membership.
- After-hours pediatric clinic.
- Pre-admission testing.

6. What can be done with unused space in the older sections of the building?

Remind students to think as HMA would in evaluating alternatives for use of space. Can competitive advantage be achieved? Can revenue be increased and costs controlled?

Lease space to other providers. For example, rehabilitation, mental health, chemical dependency, or home health could be sought out to add to the full service of RRMC. The advantages and disadvantages associated with leasing space include:

Advantages

- Guaranteed income from presently unused space.
- Excess capacity is decreased.
- Potentially could bring a new specialty area to the RRMC medical staff organization that would not be duplicated at GRMC.

Disadvantages

- If the provider specifies renovation of space as a precursor to a lease agreement, costs may not be easily recovered.
- Space will be unavailable for the duration of the lease.

Appropriate criteria for making a lease decision would include:

- Duration of lease with respect to long-range plans for space.

- Up-front costs for RRMC; potential to recover costs or future benefits from investment.

- Expected revenues from lease.

- Potential for attracting leasing provider's clients into other RRMC programs.

Renovate the space for RRMC use. Potential uses of the space include:

- Office space for physicians recruited by RRMC – physicians based at the hospital would be more committed.

- Education and training facilities – staff development, patient education, support group meetings, and other community service programs.

- Fitness center – could be staffed by physical therapists with nutritional counseling available from dietary department; could be marketed to employers as mechanism for managing high-risk employees; could be used for cardiac rehabilitation program.

- Ambulatory clinic(s) – pediatrics, allergy, others.

- Hospital-based home care programs – infusion therapy, physical therapy, respiratory therapy, other types of home care.

- Geriatric day care – could serve as feeder program and perhaps avoid unnecessary (and non-reimbursable) admissions.

7. Did county demographics suggest a specific course of action? How could RRMC establish relationships with the various smaller businesses comprising the industrial base of the county?

Etowah County was predominantly an industrial economy. This suggests that a significant portion of health care services in the area were work-related illnesses and injuries, employment physicals, and other industry-driven health services. As noted in the TOWS section of this Teaching Note, industrial medicine was not a developed service in either RRMC or GRMC. Most of the larger businesses in the area were insured under Blue Cross, which had an inherent provider-purchaser-payor relationship that precluded motivation to establish a sole provider contract for work-related services only. Therefore, marketing to capture a larger patient base from industrial manufacturing employers might be more effectively directed at smaller businesses. The MedKey program provided an excellent medium to establish contact with these businesses, many of which had fewer than 10 employees.

C A S E 12

Dr. Louis Mickael: The Physician as Strategic Manager

C. Louise Sellaro

OVERVIEW

Dr. Louis Mickael is a physician who has been in solo practice for thirty years. Beginning in the early 1980s, enormous changes have taken place within the health care industry that extensively changed the process of providing care to patients. These changes have precipitated stress and extended working hours for Dr. Mickael. At this time, three problems, or concerns, face him as he nears the age of sixty, a point in life when most people are contemplating retirement.

The first problem he must face is that health care regulatory processes are making it extremely cumbersome to carry on the activities of a physician practice. Second, the average age of his patient base has increased; the outcome is that more time and resources are required to provide care needed by these older individuals as the economic base that is available to fund their care is eroding.

The third concern for Dr. Mickael is that competitive forces are beginning to dictate a change in the way he can deliver health care to his patients. His normal mode of interaction with patients is very much the old-fashioned, "country doctor" approach. Pressures brought about by the regulatory shift that have precipitated a high degree of competition between physicians are an affront to his in-grained set of values.

These issues add up to a dilemma for the Doctor, one he feels forced to address through the evaluation of strategic directions currently available to him ranging from retirement to career change.

KEY ISSUES

1. The concept of product life cycle as it is exemplified in a health services context.

2. The extent to which a clarification of organizational objectives (as reflected by Dr. Mickael's values set) are important in an analysis of financial viability.

3. Marketing in the health care sector as a function of differentiation of service(s) provided.

TEACHING OBJECTIVES

1. To provide an opportunity for students to develop strategy and policy in a small privately-owned health care organization.

2. To illustrate that physicians' practices are businesses in today's health care environment and they need strategic management as much as any other health care organization.

3. To illustrate how the environmental changes in the health care industry have affected the lives of the major players – the physicians.

4. To illustrate that physicians have to work harder and longer hours and know more about business to maintain their standard of living.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case portrays the physician as a reactive manager. Prior to the 1980s, this attitude was adequate because financial remuneration for services provided was not predicated on development of the objectives of the firm into a strategic plan. Health care has become more regulated, and functioning within this sector requires that physicians develop a competitive strategy in order to continue "doing business."

Using a textbook approach to organizational analysis and strategy formulation and implementation (this could emanate from a general management, health care administrative, or entrepreneurial focus), the student can see the multitude of ramifications that environmental (regulatory) change holds for an industry and an organization operating within that industry.

The information provided can be organized for either written or in-class presentation format at the senior undergraduate or master's level. The student is expected to develop an environmental assessment and an internal capabilities analysis using decision support tools that have been previously addressed in class (such as TOWS, IFE, EFE, Grand Strategy Matrix, and so on). It is also expected that thoughtful analysis of alternative strategies will indicate a recommended strategy, and that plans for implementation will be included.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths

1. Dr. Mickael is an experienced, caring physician who is personable and well liked by his patients.

2. He is energetic, appears to be in excellent health, and is able to maintain a very hectic schedule.

3. As a hospital board member, Dr. Mickael is deeply involved in the medical community power structure.

4. He has a good awareness of the changing medical environment.

5. He shares space with another physician who provides patient coverage in his absence.

6. He has access to a competent computer systems consultant.

7. His client base is stable.

8. The office is in close proximity to the hospital.

9. Good financial condition – net working capital has remained around $35,000 in each of the past three years. All expenses are paid in the current quarter.

10. Dr. Mickael is in a position to exit the market with a minimum of loss. Other than the expenses of closing the office and the work involved to aid the other two doctors in renting the empty office, liquidation proceedings could commence immediately.

Weaknesses

1. The patient treatment process is often in disarray (i.e., runs late, doesn't adhere to schedule).

2. The office layout is inadequate in space and design.

3. Staff and organizational structure is disorganized and poorly managed (no full-time staff or well-trained office manager).

4. Inordinate amount of Dr. Mickael's time is spent on committee memberships.

5. Staff privileges are held at only one, small hospital.

6. There is no marketing plan other than word-of-mouth, and the patient base demonstrates great stability (little growth).

7. The office is located away from the growth center for the community.

8. Expenses are rising, revenues are not, and financial strength is eroding.

9. Aging patient base.

10. Dr. Mickael has a limited background in business management.

Opportunities

1. Greater emphasis on primary care as a method to control health care costs.

2. Businesses are increasingly interested

Threats

1. Continuous change in reimbursement methods and governmental regulations leads to decreased revenues and increased administrative costs.

in ways they can control rising health care costs as they perceive their ability to compete internationally to be threatened and to have significant impact on the bottom line.

3. Hospitals are purchasing physician practices.

4. Aging population.

2. In the health care sector, general overhead costs are increasing faster than revenue growth.

3. Urban decline.

4. Competition from hospitals.

5. Increasing number of physicians working in specialties.

6. Economic growth of areas bordering the business district.

7. Hospitals seek to move middle-aged physicians toward retirement and replace them with younger physicians.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion/product development – attainment of Family Practice certification.

2. Expansion/diversification – specialize in industrial medicine.

3. Contraction/divestiture – retiring from medical practice.

Market Entry Strategies.

1. Purchase/acquisition – purchasing Dr. Charles' medical practice.

2. Cooperation/joint venture – procuring a partner.

Value adding Service Delivery/Pre Service (Marketing Strategy).

1. Locate office away from the center-city area that would offer better opportunities for growth.

QUESTIONS FOR CLASS DISCUSSION

1. How has the health care industry changed in the past decade?

Significant changes occurred for this industry early in the decade of the 1980s. Expenditures for Medicare had approached $59 billion by 1983, and in 1984 the U. S. government initiated a prospective payment system (PPS) of reimbursement to replace the retrospective system that had previously been in use. Other private

insurers soon followed suit, reflected in the emergence of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The structural and regulatory changes have led to a situation in which financial remuneration for delivering health care is declining, in large measure because of increasing administrative costs.

The environmental impact of PPS sent out "shock waves" that have changed the profile of the health care industry. With few exceptions, the industry is comprised of structures through which services are dispensed to health care consumers quite differently from those in place at the beginning of the 1980s. It is now comprised of organizations that must compete for their share of the health care market, and who need to develop the concept of competitive strategy, not just as a precursor to growth, but often simply to survive.

2. Use an analysis of the competitive power of third-party payors as buyers, direct competitors, and the threats of new entrants and substitutes to compare the industry environment experienced by Dr. Mickael prior to the early 1980s with the environment in which he now is working, approximately ten years later.

Note: Information needed should be available from the case, a general knowledge base, and material available through any hospital, academic, or public library.

Power of Buyers

Health care is unique in that receivers of services are usually not the entities responsible for paying much of the bill for those services. In the early 1980s, a prospective payment system was developed by Medicare; other insurers followed suit, and a system of coding illness diagnoses and health care procedures (DRGs) was undertaken that is still being continually refined. The regulation has drastically changed the process of fee reimbursement for health service providers.

Power of Competitors

Direct competitors are other physicians who, for the most part, were not concerned about their share of the patient market prior to the early 1980s. This is no longer true. The market is now smaller, given that funds for care to each patient are more restricted. This means that break-even and positive bottom-line figures require service to more patients than ever before. There is now competition from other private practitioners operating solo or in groups. PPOs and HMOs may serve as aggregates of peers that can capture a portion of the patient market.

Using both horizontal and vertical integration, hospitals are directly competing with private physicians. Their organizational structures have expanded to include a broad range of for-profit and not-for-profit health services offerings, such as free-standing clinics and wellness centers.

Threat of New Entrants

There are strong financial and educational barriers to entry in this profession. Depending upon the specialty, setting up a practice could run into thousands of dollars before the physician recaptures the costs of education and practice setup. This has been true for quite a long time. Now, however, as revealed in the case, competition from this sector is not necessarily an individual effort as hospitals join forces with new entrants to reduce the entry barriers for an individual physician, and at the same time increase their competitive power over other hospitals.

Threat of Substitutes

Substitutes for the traditional health care practiced today have come about largely since the beginning of the 1980s. The rising medical costs for being ill have precipitated a strong focus on the business of staying healthy. Research on stress, for example, has provided evidence that a sound exercise program can help eliminate the deleterious effects of stressful work, overweight, and some of the aging processes. Fitness centers have been built to address a number of such programs, and indications are that a healthier populace is beginning to replace the original patient market.

3. What other environmental factors should be included in an analysis of this case?

Sociocultural – Patient Demographics

In the beginning stage of Dr. Mickael's practice, the typical patient was in his or her mid-thirties, and had an annual income of less than $20,000. Today, his patients average 58 years of age, and their average income of $25,000 does not reflect an increase that is commensurate with the increase in the consumer price index (CPI).

Nearly sixty percent of his patients are currently subsidized by Medicare insurance. The remaining patients are self-pay, or reimbursement is sought through memberships represented by Medicaid and PPOs.

Sociocultural – Physician Value Set

This physician is very patient-oriented. His approach resembles the "old-time country doctor" who is familiar with patients on a very personal basis and is often perceived as a family member because the physician-patient relationship is so intimate. This is a holistic approach to medical practice that traditionally has involved an inordinate amount of time spent with each patient; it has become an inefficient way to practice medicine in light of the regulatory structures now in place for reimbursement.

Industry Infrastructure

Hospital structures have changed dramatically in response to changing market demand. A shift in reimbursement protocol, along with technological advancement, has resulted in a much higher proportion of health care patients being treated through

hospital outpatient services. In addition, as hospitals have attempted to acquire more market share to augment declining patient bases, they have differentiated service offerings to encompass both not-for-profit and for-profit enterprises.

An additional element in this infrastructure is the expansion of certification and specialization offerings. The emergence of family practitioners and industrialized medicine are examples. The role and responsibilities undertaken by the General Practitioner have undergone a major shift. Most obstetrics and gynecological problems are now referred to specialists, as are a multitude of other patient internal diagnostic concerns.

Technological

The advances in this sector have enabled the physician to cope with the rapidly changing medical environment. Computer technology that has created "high-tech" diagnostic and therapeutic instrumentation has also made available efficient and affordable practice management hardware and software.

Economic

From 1985 through 1989 a survey by Medical Economics showed practice expenses rising at a rate well above inflation. In 1989 alone, they surged 19.8 percent, the biggest one-year jump in a decade. During the 1980s the increase in the cost of living outpaced physicians' gain in median net income.

4. What is the financial posture of this practice?

Dr. Mickael is experiencing some financial difficulty. This is confirmed by the losses of $1,827 and $1,866 in 1989 and 1990 and the income of $350 in 1991 (see Exhibit TN12.1 derived from Exhibit 12-5 in the case). The balance sheets for the same time periods disclose several areas of concern. Cash on hand has decreased approximately 46 percent, accounts receivable has increased nearly 50 percent, and stockholder's equity has declined (Exhibit TN12.2 derived from case Exhibit 12-6). The average collection period for accounts receivable (Exhibit TN12.3 derived from case Exhibit 12-6) has increased nearly 25 percent over the past three years.

Dr. Mickael's Z scores (Exhibit TN12.4) have increased. This indicator, taken by itself, is optimistic, and although his profitability would indicate otherwise, he is still paying bills with current assets and does not have any debt. However, in diagnosing any case, ancillary support tools can render an invaluable "second opinion."

5. Given that Dr. Mickael prefers not to retire just now, what recommendations exist for him?

Accept City General's offer to provide financial backing for a new physician certified in family practice to join Dr. Lou's practice in anticipation of his retirement within the next few years.

Pros:

- Will increase the ability of the practice to handle a larger volume of clients.
- Will take away some of the responsibilities from Dr. Mickael.
- Will add another person to top management that will increase the objectiveness of decision-making.

Cons:

- Will require additional space that does not presently exist.
- May be difficult to attract a partner considering Dr. Mickael's aging patient base and the demographics associated with the current location.
- Will add salary expense.
- Will require Dr. Mickael's adjustment to no longer being the sole decision-maker.

Buy Dr. Charles' practice.

Pros:

- Will provide room for a new physician on Dr. Mickael's staff.
- Will provide an immediate influx of new patients, many of whom are already familiar with Dr. Mickael.
- Should alter the current patient mix and improve the financial position.

Cons:

- Will require sizable investment.
- Will increase expenses, including rent, which is allocated on a square foot basis.

Reorganize the office staff in line with needs related to current industry constraints.

Pros:

- Should increase cash flow through speedier forms processing, thereby reducing accounts receivable.
- Will improve client satisfaction through more efficient handling of forms and processing of claims.

Cons:

- Will add to expenses.
- Will probably necessitate termination of one, or possibly two, of the current staff. This would not head the list of Dr. Mickael's priorities.

Rearrange the office layout in the existing structure or, move to new quarters with a layout better suited to Dr. Mickael's needs.

Pros:

- Will increase office efficiency.

Cons:

- Will require considerable expenditure.

Become certified in the field of Industrial Medicine and obtain a position with a local company.

Pros:

- Will free Dr. Mickael of the "long days" in the office.
- Will reduce stress level for Dr. Mickael.
- Will allow someone else to "handle the business" so that all Dr. Mickael has to do is practice medicine.

Cons:

- Will require an investment in time and money.
- Will require that Dr. Mickael find an employer in a satisfactory location.
- Will require that Dr. Mickael leave a practice in which he has considerable time and emotion invested.
- Dilemma associated with concern about abandoning current patients.

Backward or forward vertical integration as a SPACE analysis suggests that Dr. Mickael's strategic position is in the "Competitive" sector, indicating an unstable industry, but a practice profile that has some financial stability. Therefore, another alternative that is appropriate for firms in the competitive vector is either forward or backward integration to add programs of health maintenance and illness prevention (forward), or the addition of a testing facility (backward).

Pros:

- This could add convenience for patients, and increase the marketing function as more and more individuals go through the facility.
- Offers the possibility for partnership with other physicians, thus becoming a broader marketing tool.

Cons:

- Will entail addition of staff and an increase in expenses and investment.
- Will require additional business management time and focus, neither of which Dr. Mickael has in great supply.

EXHIBIT TN12.1 Dr. Louis Mickael
Statements of Income for the Years Ended December 31

	1991	1992	1993
Operating revenue:			
Professional fees	$172,281	$172,472	$204,910
Interest income	992	456	210
Total revenues	173,273	172,928	204,910
Operating expenses:			
Salaries	117,455	124,608	132,325
Professional dues and licenses	1,925	1,873	1,816
Misc. professional expenses	1,228	2,246	3,232

Drugs and medical supplies	2,550	1,631	2,176
Laboratory fees	2,629	524	1,801
Meetings and seminars	2,543	838	3,880
Legal and professional fees	5,525	2,057	5,400
Rent	16,026.00	16,151	18,932
Office supplies	4,475	3,262	4,989
Publications	1,390	406	401
Telephone	1,531	1,451	2,400
Insurance	8,876	9,629	11,760
Repairs and maintenance	3,547	4,240	5,352
Auto expense	1,009	1,487	3,932
Payroll taxes	3,107	2,998	3,780
Computer expenses	846	938	1,905
Bank charges	438	455	479
Total operating expenses	175,100	174,794	204,560
Net income (loss)	($1,827.00)	($1,866.00)	$350

EXHIBIT TN12.2 Dr. Louis Mickael
Balance Sheets at December 31

	1991	1992	1993
Assets			
Capital equipment			
Medical equipment	$11,722	$11,722	$11,722
Furniture and fixtures	3,925	3,925	3,361
Less-accumulated depreciation	6,477	9,094	11,891
Total capital equipment	9,170	6,533	3,192
Current assets			
Cash	15,994	9,564	8,666
Petty cash	50	100	100
Accounts receivable	19,081	25,054	28,509
Total current assets	35,125	34,718	37,275
Total assets	$44,295	$41,271	$40,467
Liabilities			
Current liabilities			
Income taxes payable	639	653	123
Dividends payable	1,158	1,154	1,154
Total current liabilities	519	501	1,277
Owner's equity			
Net income (loss)	(1,188)	1,213	229
Less: dividends	1,158	1,154	1,154
Retained earnings	(2,346)	(2,367)	(925)
Capital	46,122	43,137	40,117
Total owner's equity	46,122	40,770	39,192
Total liabilities and owner's equity	$44,295	$41,271	$40,467

EXHIBIT TN12.3 Dr. Louis Mickael
Average Collection Period in Days for the Years Ended December 31

	1979	1986	1991	1992	1993
Accounts receivable/ (annual credit sales/365)	48.95	85.54	40.43	53.02	50.83

EXHIBIT TN12.4 Dr. Louis Mickael
Z Scores at December 31

Variable	1991	1992	1993
X1 = Working Capital/Total Assets	.79	.84	.92
X2 = Retained Earnings/Total Assets	1.00	1.00	1.00
X3 = EBIT/Total Assets	(.04)	(.05)	.01
X4 = Market Value of Equity/Book Value of Total	0.00	0.00	0.00
X5 = Sales/Total Assets	3.89	4.18	5.06
Z = 1.2X1 + 1.4X2 + 3.3X3+ 0.6X4 + 1.0X5	6.10	6.42	7.60

where EBIT = earnings before income tax