

CASE 13

Emanuel Medical Center: Crisis in the Health Care Industry

OVERVIEW

Emanuel Medical Center (EMC) of Turlock, California was founded in 1917. As of December 2002, its core business consisted of a 150-bed full-service hospital. The hospital also had an acute care facility, a 24-hour emergency services department (ED), an ambulatory surgical unit, an outpatient diagnostic facility, a home health department, a hospice, and an occupational medicine clinic. Near the main complex, EMC operated a skilled nursing facility and a small assisted living facility.

Mr. Robert Moen, President and CEO, was experiencing a number of challenges. First, there had been significant negative attention for EMC following newspaper accounts and a state investigation of the Haley Eckman incident. Second, the emergency department at Emanuel Medical Center was experiencing increasing pressure to deliver services in an increasingly difficult health care environment, particularly in light of federal EMTALA legislation that required access to emergency medical care for all – regardless of ability to pay. The cost of operating the emergency department had risen precipitously; patient flows vastly exceeded the capacity for which the ED had been designed. Third, reimbursements for services from HMOs and government programs had been drastically reduced, while paperwork and other regulatory burdens had increased. Fourth, for-profit managed care facilities were making significant incursions into EMC's service area. Fifth, EMC was beginning to experience a nursing shortage that was driving up EMC's cost of operations.

The net effect of all of these factors combined put increasing pressure on EMC's operating margins that had been negative for some time. This pressure on operating margins had been exacerbated by an increase in underinsured and uninsured patients in the ED. Moen was beginning to realize that EMC's survival as an ongoing operation was threatened.

Moen was considering several options: whether to merge the hospital with a competing health maintenance organization (HMO), sell the hospital, close the ED, or close the hospital outright. Another option under consideration was to do nothing and try to maintain the status quo while dealing with the hospital's myriad operational issues.

TEACHING OBJECTIVES

This teaching note was prepared by Randall Harris, Kevin Vogt, and Armand Gilinsky as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation. © 2004 by Randall Harris, Kevin Vogt and Armand Gilinsky. Used with permission from Randy Harris.

This case was designed for graduate-level courses in health care management. The case provides an illustration of the significant pressures faced by the management of a rural not-for-profit health care facility. Because of its complex nature, a suggested time to teach this case would be after the class has had an overview and some discussion of the overall US health care industry. An industry note that complements the EMC case is “Case 1: The US Health Care System – Participants, Financing, and Trends: An Industry Note” by Stuart A. Capper in *Strategic Management of Health Care Organizations*, 5th edition, Swayne, Duncan, and Ginter (Oxford: Blackwell Publishing, 2006).

In addition, the case provides the opportunity to introduce and discuss both stakeholder analysis (see Swayne, Duncan, Ginter, *Strategic Management of Health Care Organizations*, 5th edition, (Oxford: Blackwell Publishing, 2006, p. 81) and stakeholder theory (see R. Freeman, *Ethical Theory and Business*, Englewood Cliffs, NJ: Prentice Hall, 1994). EMC’s current financial status and its deeply imbedded relationship with its surrounding community provides a graphic illustration of the effect that several large, powerful stakeholders with countervailing incentives can have on an organization.

The case attempts to provide a framework that students can use to debate the major strategic concerns currently faced by CEO Moen. Financial analysis skills on the part of students are assumed; this analysis should lead students to conclude that the soundness of EMC’s balance sheet is weakening. In particular, the EMC facility was consistently facing a loss from operations. Yet was closure of the facility (or the ED) really an option, either for the hospital or the broader community? Further, the increasingly hostile competitive and regulatory environment for rural hospitals is graphically illustrated.

Finally, the EMC case provides an excellent case study of the dilemma posed to the greater health care community regarding the increasing closure of rural hospitals. See “Issue Nine: Rural Hospitals Are Important Parts of their Communities and Provide Essential Health Care Services Not Otherwise Available” in *Strategic Issues in Health Care Management: Point and Counterpoint*, Duncan, Ginter, and Swayne (Boston: PWS Kent Publishing, 1992), pp. 184–199.

INTENDED COURSES AND LEVELS

EMC was designed for graduate level courses in health care management. The case assumes that students have at least basic coursework in accounting and finance. The case can be quite challenging for undergraduate students of health care management.

SUGGESTIONS FOR EFFECTIVE TEACHING

The case can be taught in two one-hour classes or in one 90-minute class period. The case requires comprehensive student preparation to have an effective discussion. The authors recommend a student writing assignment prior to class. Class could begin with an overview of the financial condition of EMC, followed by a discussion of the increasingly difficult health care environment, the particular circumstances of EMC, and finally the alternatives that Moen is considering.

Two representative student papers are included in this Note as Exhibit 2 and Exhibit 3.

RESEARCH METHODOLOGY

The research for this case was conducted by interviews with company employees, senior management, and customers. In addition, a co-author of this paper served as CFO for EMC. All of the actual names within the case are real. Financial data is publicly available and sources are cited in the document and exhibits.

QUESTIONS FOR CLASS DISCUSSION

1. Discuss the strategic options available to President Moen: merge the hospital with a competing health maintenance organization (HMO), sell the hospital, close the ED, close the hospital, or do nothing and try to maintain the status quo while dealing with the hospital's myriad operational issues.

- a. Merge the hospital with a competing health maintenance organization (HMO). The HMO that was pushing hardest against EMC was Kaiser. It had significant growth in membership in the past four years in EMC's primary market area and was anticipated to continue to move aggressively into expanded coverage. The decision that Kaiser makes regarding new facilities and providers in EMC's primary market area could put significant pressure on EMC's operations. Emanuel could come under significant pressure to sign a Kaiser contract.

Alternatively, EMC could consider merging with the Kaiser organization (or another HMO) outright. Superior students will recognize that EMC's independent operation is increasingly untenable without the significant presence of an HMO.

- b. Sell the hospital. If the long-term survival of Emanuel is threatened, then the possibility of selling to a for-profit chain could be explored. The struggle to maintain profitability while pursuing an aggressive growth strategy highlights the risks faced by EMC. Failure to attract a well-paying patient base could jeopardize the survival of EMC. If this were to happen, Moen may want to consider selling the hospital.

Many markets in California have seen the closures of hospitals in the recent past. For Turlock, this would be a heavy blow. If the hospital was sold to a large competitor in Modesto, such as Doctors Medical Center (DMC), then the efficiencies of operating two hospitals with one common overhead structure could result in operating gains. The capital raised from the sale could help to develop the services EMC needs to grow.

This solution could keep medical care in the community rather than facing outright closure. As the hospital is a not-for-profit entity, any purchase by a for-profit entity would require the establishment of a

foundation to carry on the charitable mission that was established by the original founders of EMC. This new foundation could set up more health clinics for the underserved in the community as well as develop wide ranging health education programs to provide preventative care. Superior students will point out, however, that this solution will likely be unpalatable to EMC's stakeholders.

- c. Close the ED. Superior students, recognizing the financial drain on EMC's resources, may suggest the closure of the ED. However, as the case points out, half of EMC admissions came through the ED, making the ED closure a risky financial proposition. It is also likely, on the basis of comments by significant stakeholders in the case, that ER closure may not be politically feasible.

Students should then be ready for a discussion of the utilization of the ED's resources. How do typical ED patients utilize the facility? Superior students should point out that a great deal of time and resources are spent in the ED on primary care, and that this utilization is both inefficient and costly. However, in the absence of the EMC ED, where will these underinsured and uninsured patients seek primary care?

- d. Close the hospital. The question that will probably come up in discussion is: "Why not close the hospital since it's not making any money anyway?" This question may provide a basis for some discussion of stakeholder theory. According to R. Freeman, *Ethical Theory and Business* (Englewood Cliffs, NJ: Prentice Hall, Inc., 1994), there are two senses to what a stakeholder could be in a corporation. In the narrow sense, these are the groups vital to the survival and success of the corporation. In the "wide-definition" sense, these are any group or individual who can affect or are affected by the corporation.

Then the question really becomes, "Who are the stakeholders in Emanuel Medical Center?" Taking the "narrow" stakeholder approach, it is reasonable to conclude that both the state and federal governments are stakeholders in EMC's operations, particularly when EMC acts as the delivery mechanism for government programs. But then isn't this everybody? It may be useful at this point in the discussion to conduct a stakeholder analysis of EMC (Swayne, Duncan, and Ginter, *Strategic Management of Health Care Organizations*, 5th edition, (Oxford: Blackwell Publishers, 2006, p. 81) to make explicit the point that the various stakeholders will have very different agendas during a debate regarding the closure of EMC.

Of course, one could move away from such a broad argument with regard to EMC's stakeholders and argue that the local community is really the vital stakeholder. Then doesn't the local community have a vested interest in seeing that the hospital remains open? What about the public interest of serving the medically underinsured and uninsured?

Regardless of the flow of discussion, the core issue that superior students will discern is the tension in health care between the neo-classical profit motive of corporations and the broader issues related to serving the greater public good. The place where this dilemma is currently playing out at EMC is in the emergency department, where the greater public good appears to be bankrupting the hospital. Or is it just the transfer payment mechanism?

The larger issue playing out in the EMC case is the dilemma posed to the broader health care industry by the closure of rural hospitals. An excellent source that discusses the debate surrounding the closure of rural hospitals is “Issue Nine: Rural Hospitals Are Important Parts of their Communities and Provide Essential Health Care Services Not Otherwise Available” in *Strategic Issues in Healthcare Management: Point and Counterpoint*, Duncan, Ginter, and Swayne (Boston: PWS Kent Publishing, 1992), pp. 184–199.

- e. Do nothing. Superior students will quickly point out that a maintenance of scope strategy will require an intense focus on the numerous pressing operational issues faced by EMC. Discussion of the “do nothing” option should quickly lead into a discussion of the numerous operational issues that have now become critical at EMC.
2. What are the most pressing operational issues President Moen should address?
- a. ED operations. The volume of patients that come through the emergency department is crippling the bottom line at EMC. Although capacity exists elsewhere in the hospital, the need for additional emergency department space is becoming quite pronounced. Emergency space is structurally close to its maximum, morale appears to be slipping, and adequate staffing is becoming increasingly difficult to maintain. The waiting area in the emergency department is overflowing many days. An expansion of the facility could be considered, but the financing of this expansion may not be feasible given the current fiscal scenario and the deficit that operations are running. ED operations will continue to be a significant issue until operating results improve.
 - b. Uninsured patients. The overcrowding issue in the emergency department is caused partly by the high volume of Medi-Cal patients that are coming for routine care. These patients have a difficult time obtaining primary care through the traditional physician outpatient practice environment because of low reimbursements by state and federal programs. If a solution could be developed to allow more routine care for Medi-Cal patients, then the burden of caring for them in the expensive emergency department could be reduced. The quality of medicine would be improved by continuity of care.

It is conceivable that a federally subsidized clinic could be built very close to the emergency department and operated in the evenings and on weekends as well as during the day. With this support, triage nurses could assess patients as they enter the emergency department and direct patients to the clinic rather than to the emergency department for treatments that are appropriate.

The reimbursement for a federal clinic is much higher than both the emergency fees paid to hospitals and the outpatient fees paid to physicians in their offices. For this reason, the hospital could contract with current physicians to staff the clinic or recruit new physicians to work in the clinic. By moving this volume out of the emergency department, the need for additional space could be mitigated. With the high cost of adding space in hospital facilities, it would appear that opening a federally sponsored clinic could be an efficient use of capital and fulfill a need in the community.

- c. Staffing Shortages and Rising Staff Costs. EMC's staffing shortages and rising costs, particularly for nursing staff, appear to closely match the difficulty faced by other hospitals and health care facilities nationwide. Superior students will point out that, barring a significant reversal in current trends, this issue is likely to persist and even grow worse for EMC. Further, addressing this issue adequately would appear to be beyond the limits of one hospital.
- d. Inadequate reimbursements and heavy regulation from government agencies. Superior students will also point out that the reimbursement and regulatory environment of hospitals is national, suggesting that these issues are perhaps best addressed at the State and Federal level. Some students may become frustrated that EMC can not (apparently) effect change in one of EMC's largest revenue streams, or in the regulatory environment that accompanies this revenue stream. Further, students may be unable to reconcile the desire to cap health care costs for themselves against the knowledge that these efforts are apparently bankrupting EMC.
- e. Patient mix. Part of the problem EMC is facing appears to be with regard to patient mix, (not having enough high paying customers to balance the influx of low paying customers). To attract and retain a more affluent mix of patient, EMC will need to develop the additional kind of services (such as cardiac care) that attract patients that have the highest capacity to pay for services (or the best insurance coverage).

One way to do this would be to develop a cardiac catheterization lab. This is a significant undertaking and would require the recruitment of several cardiologists and building expensive facilities to support their practice. It would, however, allow EMC to compete directly with the larger facilities in their service area.

The entire cardiac care product line would be enhanced with the installation of a catheterization lab. The current patient base could expand

with more cardiac services and the support available to nursing staff would be enhanced with more cardiologists. Cardiology will continue to grow as a service line with the aging of the US population. This growing demographic as well as the high reimbursement levels for cardiac care is a strong reason to move in this direction.

The more high-level services offered, the more people will also seek out Emanuel for routine care. The image of a full-service hospital with capable staff, high technology, and high touch is important to compete for the best-paying patients.

- f. Restoring Operations to Profitability. How? The main revenue streams for EMC are managed either by government programs or for-profit HMOs. Both entities have a vested interest in reducing costs and minimizing the level of reimbursements for procedures. On the cost side, labor costs are rising sharply, particularly in nursing. With regard to customer inputs, the fastest growing customer segment for EMC is the medically underinsured and uninsured.

When superior students begin to move back in this direction, the flow of discussion may revert back to stakeholder theory, or may push the discussion into suggestions for reform of the entire health care system.

Given that EMC's capital reserves are currently subsidizing operations, another approach to keeping the doors open would be to continue to use fundraising as a significant source of funds for operations. Although this strategy may not be viable in the long run (particularly if losses from operations are eventually unsupportable), it may represent an adequate short-term measure. The difficulty with regard to this approach is that it does not address the fundamental weakness at EMC: the hospital is not even at breakeven with regard to operations.

3. Perform a financial analysis of EMC. What does your analysis reveal? Where is the company strong and where is it weak?

EMC posted total income of \$4.7 million in FY01, which is a total margin of 6.3 percent. However, during the same year, EMC lost over \$4.1 million on operations. This is a direct result of the growing costs of salaries and wages as well as the increase in losses on the HMO capitation contracts. Over the five-year period of capitation for EMC, all but the first year resulted in operating losses.

Expenses over the past three years had grown at a rate of 7.7 percent per year with salaries and wages (combined with benefits) growing at 4.1 percent. However, in FY02, EMC raised starting nursing salaries over 27 percent. Capitation expenses grew during the five-year period from \$655,000 to \$8.9 million. More importantly than the absolute dollars paid out for capitation services was the percentage of premium revenue that was given to other providers for services rendered by them for EMC covered lives. In FY97, 34 percent of premium revenue was paid out to other providers for health care services to members capitated to EMC. But in FY01, 54 percent of the revenue received went to other

providers. This increased the losses on capitation and eventually led to the exit of EMC from this payment mechanism.

Emanuel had a strong balance sheet but was experiencing weak (and deteriorating) operating performance. Investments by the Board of Directors in 1992 resulted in a growth of investments to \$53,339 compared with an industry median of \$21,760. EMC's low debt to asset ratio of 0.36 continued to show the strong focus on balance sheet performance. Long-term debt was at \$24,426, in 2001 29.4 percent below the industry comparison of \$34,609 latest available was 2001 data. This analysis appears to reveal a capacity to add up to \$10,000 of new debt to fund needed expansion plans. However, the strong balance sheet was more than offset by weak earnings on operations.

For the period FY97 to FY00, Emanuel's primary market share declined from 62.6 percent to 58.8 percent. Memorial Hospital of Modesto increased its market share in the same market from 8.8 percent to 11.2 percent and Doctors Medical Center of Modesto increasing from 12.5 percent to 13.6 percent. The primary driver for Memorial's growth in market share was attributed to Kaiser's membership growth during the same period. Emanuel lost market share in its secondary market – from 9.4 percent in FY97 to 8.7 percent in FY00. Both Memorial and Doctors Medical Center increased their market share by 2.6 percent during the same period.

FY97 was the first year that Emanuel entered into capitated arrangements with HMO health plans. During the five years of capitation, total operating revenue decreased by 4.7 percent. This was very significant when compared to total expenses that increased by 7.4 percent. The result was that operating margins went from a positive 4.2 percent to a negative 8.0 percent in the last year of capitation.

The return on equity in FY97 was 4.7 percent with operating income of \$2,185. This was the last year of earnings from operations during the period. However, the ROE decreased to negative 6.5 percent in FY00 on operating losses of \$4,139,000 as capitation took its toll. A chart of the financial analysis described here is contained in Exhibit 1.

4. What strategic option would you recommend to President Moen?

After a class discussion, most of the hospital's strategic options will probably drop from the list of potential alternatives. Doing nothing is probably the most untenable because of the enormous pressures being exerted by EMC's various stakeholders and the declining reimbursements from state and federal programs. Powerful stakeholders in the community would be likely to react quickly and decisively to block any attempts to close the hospital or close the ED. Selling the hospital outright would probably be equally as controversial. Comments made in the case to Moen after he jokingly mentioned closing the hospital should amply illustrate the peril to Moen regarding these courses of action.

After some discussion, students will probably come around to the alternative of merging the hospital with a competing HMO. Although that recommendation might ensure the hospital's survival, at least in the short run, it is likely to be unpalatable to many of

EMC's stakeholders, most notably its physicians and staff who have enjoyed a relatively large amount of autonomy. This autonomy would likely be curtailed following an HMO merger. The deep pockets offered by such a merger, however, should allow EMC the ability to upgrade operations, attempt to get a handle on costs, and allow for a better negotiating posture with state and federal agencies. This alternative, though unpalatable, is likely to emerge from class discussion as the best course of action for EMC. Superior students should be quick to point out the difficulties of implementing such a merger and the likely post-merger decline in hospital morale.

EPILOGUE

Robert Moen retired as President and CEO of Emanuel Medical Center in October 2002. Mr. Moen spent 33 years at Emanuel. Thomas M. Johnson, 59, was named as Interim CEO until a replacement for Mr. Moen was selected. A national CEO search was started. In November of 2002, EMC signed a deal with Kaiser Permanente to treat Kaiser patients in the Turlock area. EMC and Kaiser officials, in announcing the agreement, said that it would take place April 1, 2003 pending state regulatory approval. About 11,000 patients in Turlock, Denair, and Hilmar had insurance with Kaiser at the time the deal was announced. Immediately following the announcement of the Kaiser deal, Kevin Vogt, the CFO of Emanuel, announced his resignation.

In early 2003, Kaiser canceled its service contract with Memorial Hospital in Modesto; all Modesto Kaiser patients would now have to seek care either in Stockton or Turlock. Kaiser announced plans to break ground on a new hospital in Modesto. Construction was estimated to be completed in 2006.

In March 2003, John Sigsbury, the former vice president and Chief Operating Officer for the Frederick Memorial Healthcare System in Frederick, MD, was named president and CEO of Emanuel. Mr. Sigsbury completed a nationwide search for his administrative team in July 2003.

In August 2003, Emanuel announced the beginning of a capital campaign for a new emergency department. The stated goal of the campaign was to raise \$6.5 million in the first phase and \$13 million for the next phase. EMC has announced that it will break ground for the new facility in Spring 2005.

SUGGESTIONS FOR FURTHER READING

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EXHIBIT 1 EMC Financial Analysis FY1997–FY2002

	FY97	FY98	FY99	FY00	FY01	FY02
Sales (000s)	\$55,772	\$54,590	\$54,466	\$55,971	\$56,145	\$68,560
Sales Growth	N/A	2.1 %	0.2%	2.8 %	0.3 %	22.1 %
Net Income (000s)	\$4,548	\$3,055	\$4,795	\$9,034	\$4,677	\$480
Net Income Growth	N/A	(32.83 %)	56.96 %	88.40 %	(48.23%)	(89.74 %)
Profitability Ratios						
ROE	9.76%	6.29%	8.60%	13.35%	7.31%	0.76%
ROA	5.55%	3.66%	5.21%	8.61%	4.65%	0.49%
Operating Margin	3.92%	2.19%	0.62%	1.31%	7.37%	0.19%
Liquidity Ratios						
Current Ratio	1.48	1.58	1.40	1.23	1.12	1.72
Quick Ratio	1.37	1.47	1.30	1.14	1.04	1.61
Leverage Ratios						
Debt/Assets	0.43	.042	0.39	0.36	0.36	0.35
Debt/Equity	0.76	0.72	0.65	0.55	0.57	0.53
Activity Ratios						
Total Asset Turnover	0.68	0.65	0.59	0.53	0.56	0.71
Fixed Asset Turnover	1.55	1.61	1.66	1.79	1.84	2.30

Source: EMC

EXHIBIT 2 EMC Case Assignment Student 1

Central Issue: With a trend of consolidation in U.S. Hospitals, independent hospitals like EMC are faced with financial and operating problems.

- EMC is faced with increasing pressures from its macro environment.
- EMC's ED is rapidly draining needed resources leading to high operating expenses.
- Competition is increasing with rival hospitals expanding their facilities, threatening independent hospitals.

A company's macro environment consists of external factors that can affect a company's business process. Some of these macro environment factors are technology, societal values and lifestyles, population demographics, legislation and regulations, and the economy at large. EMC is an independent hospital located in Turlock, California and opened more than 80 years ago. Over the past 80 years, new regulations and legislations have been made by the government to try and improve a constantly changing medical environment. Some of the new legislation and regulations have threatened EMC's operations. A federal law called EMTALA (Emergency Medical Treatment and Active Labor Act) was passed that said emergency departments had to treat patients in need of medical attention even if they had no means of paying for the treatment or little or no insurance. This law turned out to be a nightmare for EMC and many other hospitals. Ethically, this is a good law to protect patients that needed medical attention, but on the other hand the government gave no aid to hospitals to help them pay for this law. For EMC, this meant that funds for treatment that these patients were not able to pay for came right out of EMC's pocketbook. Not only did the EMTALA law hurt EMC financially, it also increased the patient load when EMC had problems with staffing. Nurses in California were scarce, not to mention that their salaries were increasing. Sometimes, EMC had to hire temporary nurses that had to be paid more than full time nurses. Another macro environment factor that affected EMC was an aging population. In 1999, 56 percent of acute patients that had been treated in the ED were 45 years of age or older. This means that EMC has a growing number of patients that will need more frequent medical attention because of an increase of the elderly population. Lastly, medical technology is increasing all the time so supplier power is very high. EMC and other hospitals need the best equipment possible and the best pharmaceuticals on the market, so suppliers can charge very high prices for their goods and EMC has no option but to purchase them.

EMC's ED department seems to be the cause of their largest problem. EMC has shown an increase in operating revenue since 1999 from \$54,466 to \$68,560, which looks good to the naked eye. But, if you look at their operating expenses you will see that they are greater than operating revenue every year since 1999. The only thing that has kept them somewhat afloat has been revenue from non-operating related sources and investment of that money into the stock market, which generated over \$50 million. The ED has increased its operating expenses because the staff has to treat patients all the time that are under insured, that have HMO plans, and patients that fall under the EMTALA law. Not to mention that the wages for nurses and doctors have increased drastically as well. Looking at EMC's return on sales from 1999, which were at 13 percent until 2002, which dropped

to a -3 percent, you can see that EMC is not getting paid adequately from patients and insurers to cover its costs. Also the average collection period has increased from 70 days in 1999 to 73 days in 2002. This is not a large increase but EMC has to wait on average over two months to get paid which is a long time. With EMC's lack of staff, patients are receiving mediocre to poor service because nurses are overwhelmed with patients leading to mis-diagnosis. Patients want quick and accurate treatment, but EMC cannot offer that with understaffing.

EMC is hanging on by its last strings. It is not obtaining the proper revenue to pay its staff, expand, and be financially sound. EMC is the last independent hospital since 1995 to still be operating. The potential for new entrants in their market is relatively low but rivalry among competitors has been increasing every year. Kaiser is potentially a great threat to EMC (they have plans to spend \$1 billion in the Central Valley and build hospitals in Sacramento, Stockton, and Modesto and possibly a new hospital that would be located in EMC's primary service area). Other competitors such as Sutter, Tenet, and Catholic all operate hospitals in EMC's secondary service area with much larger facilities and larger pocketbooks. There has also been a trend of consolidation among hospitals, which could very easily happen to EMC and might even be a wise option for Robert Moen to pursue.

EMC has been doing a downward spiral for the past three years and is faced with an increasingly difficult market. Looking back at Haley Eckman's case, this is a good example to illustrate EMC's lack of staffing and government legislative pressures have inched EMC further away from their mission statement and core values. EMC cannot provide patient satisfaction, excellence, and high quality service as stated in its vision and values when they have ED patients waiting for three hours and then don't even get the proper treatment. EMC has no means to improve its services when the finances are not there and staff morale is nowhere to be found. EMC is being eaten alive by its competitors and desperately needs to partner up with a sister hospital to properly provide quality health care for its community.

Prepared by Thomas Corwin, October 2, 2003

EXHIBIT 3 EMC Case Assignment Student 2

The board of directors of EMC should capitalize on recent opportunities in the service area to help solve their major weaknesses and threats.

- Contract with Kaiser Permanente
- Expand hospital with non-operating revenue/Kaiser revenue
- Build on existing community support

The overall US health care industry at this time is one where the industry is beset with rising costs, closures, and consolidations. This may lead someone to conclude that now is not the time to expand their hospital. I disagree because failure to do so would prevent EMC from reaching their objectives or goals. Emanuel Medical Center's mission centers on providing quality health services for a healthier community. They are not meeting this mission or the goals they have set out for themselves. In looking at the competitive forces in the industry I see the rivalry among the existing firms to be moderate. I believe that they can reach their goals if they capitalize on recent opportunities in their service area.

First they need to try to form a partnership agreement with Kaiser, their main competitor, to help serve the 60,000 plus persons insured by Kaiser in Stanislaus County. This opportunity has just opened up because Kaiser and Memorial Hospital's partnership contract has expired. If they form this partnership they will be able to bring in more operating income to solve their major weakness of negative operating income. Because of rising costs in the industry, EMC has been bringing in negative operating incomes over the past 5 years. Finding additional sources of operating income is imperative to EMC reaching its objectives and fulfilling its mission. This partnership will also solve the major threat of Kaiser Permanente perhaps moving into EMC's primary service area. Of all of EMC's competitors only Kaiser poses a threat to their primary service area. Only Kaiser has the resources to compete directly with EMC in this primary service area. Kaiser would choose to enter into this agreement because it would help them service their insured customers as well as save them the cost of building a hospital in the Turlock area. Right now hospitals are trying to cut corporate expenses so this agreement would be attractive to Kaiser. What else can EMC do to solve their major weaknesses and reach their objectives?

EMC can expand or modernize its hospital with non-operating revenue and increased operating revenue from the Kaiser contract. To reach their goals of (1) caring for their customers and each other, (2) providing clinical, operational, and service excellence, and (3) growing revenue, facilities, and people, they need to expand. Expanding their hospital is achievable because of their strength of bringing in positive non-operating revenue over the last five years as well as the Kaiser revenue. The demand for increased service is there because of increased population, the aging of the population, and recent hospital closures in the area. It would be wise to meet this need in order to bring in new revenues over the coming years. Because this is an older hospital they need to expand and modernize in order to meet the needs of the community. They could modernize their emergency room in order to deal with increased customers choosing this as their primary means of health care. Expansion of their existing hospital might also attract new medical personnel to their

hospital also. Quality doctors and nurses are attracted to newer and modern facilities. I saw this as a major weakness for EMC as well as the industry as a whole. There has been a difficulty in attracting and retaining quality medical personnel. This expansion would improve morale definitely with their existing employees.

This expansion is also possible because they are a not-for-profit charity. Donors are given a significant tax advantage for their donations. EMC donations have increased over the last four years. This is one of their strengths actually because the community sees this hospital as their own. EMC needs to build on this community support and give the community the resources they need. They would be fulfilling their mission here. If EMC was a for-profit corporation the community would not give EMC what it would need to prosper. My conclusion is that they need to seize on the opportunity to expand because the demand is there to do so. This seeking of new revenue will solve the major threat of Kaiser as well as deal with the weaknesses of negative operating incomes, emergency room problems, and in the attracting and retaining of quality medical personnel. Some of their threats and weaknesses can't be solved or lessened because they have no control over them but they should try to alleviate the ones that they can. Doing so would help them achieve their mission and their goals.

Prepared by: Paul Galassi, October 1, 2003

CASE 14

Cooper Green Hospital and the Community Care Plan

OVERVIEW

Dr. Max Michael, CEO of the Jefferson Health System, had the difficult responsibility of balancing cost with care, of rationing procedures with policy, and of juggling personnel with budgets, performance, and demand. Despite the daunting tasks that came with being Chief Executive Officer (CEO) for a county public hospital, he spent two afternoons a week manning the front lines because he believed it was important to know the people whose lives would bear the burden of his policies and decisions. It was there, on the front lines, where he had first encountered the nature of the health care problem and had a vision for its solution.

Community Care Plan (CCP), an innovative approach to delivering health care to the county's indigent population, was started only through Dr. Michael's perseverance, the dedication of small cadre of believers, and a sizeable grant award. The grant was ending and Dr. Michael was faced with deciding the future of CCP. It was his "pet project," his vision for improving health care for the county's population. He had to admit it had met with only limited success. Should he forge ahead with expansion plans to try to achieve a critical mass, hold steady until they worked out their "growing pains," or give up on the plan altogether? He must make this decision in the context of a rapidly changing health care environment, depletion of the grant, and numerous organizational constraints. How would the indigent of Jefferson County receive care?

KEY ISSUES

1. Illustration of the impact of a changing health care environment on a public hospital – health care costs are rising and sources of funding are declining.
2. Flexibility is required to compete, but "safety net" providers often have restrictions limiting their ability to change with a changing environment.
3. Illustration of the complexity of creating a successful primary care network.
4. Consideration of numerous external and internal factors to decide the future of the network, and, implicitly, the hospital.
5. Providing health care for an indigent population has unique problems and requires unique solutions.
6. More than a vision is required to develop new, different ways to deliver care.

This teaching note was written by Alice Adams and Peter M. Ginter, University of Alabama at Birmingham, and Linda E. Swayne, The University of North Carolina at Charlotte. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from Alice Adams.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Understand the impact of a rapidly changing external environment on a public agency.
2. Discuss how a public agency, through visionary leadership, can innovate and change.
3. Understand the importance of organizational structure and culture in implementing strategic plans.
4. Apply strategic management in a chaotic health care environment.
5. Determine a course of action for the Community Care Plan and Cooper Green Hospital.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case is appropriate for graduate courses in health care strategic management, health administration, or public health policy. For health care strategic management students, the instructor may focus on creating a fit with the environment; organizational issues such as structure, culture, and implementation difficulties; and decision making under significant uncertainty. For public health policy courses, the analysis may focus on the development of public health programs, the unique problems and solutions of health care delivery to poor populations, and partnering with other community agencies.

A good beginning question to ask students is, “Why haven’t patients such as Martha James not signed up for CCP?” The major discussion point will be that they do not know about it but other answers are also important. The patients do not know what it means to have a primary care provider as they have always gone to the ER for care – and although slow, they do receive care. They can’t afford to be sick; it costs too much to pay for CCP.

It takes time and money to build awareness for a new service. Can CGH find the funding to gain awareness? Can it be done in time (before the grant runs out)?

Three different groups can be assigned to each of the choices for Dr. Michael: move ahead with expansion plans to achieve critical mass, try to maintain the status quo with the program while culture and structure issues are resolved, or close down the Community Care Plan. Each of the groups can present the benefits of the assigned alternative in turn and after each team has presented, they can point out the problems associated with the other alternatives.

STRATEGIC ALTERNATIVES

1. Maintenance of Scope/enhancement – market entry/alliances with other providers (health department, children’s hospital).
2. Value adding support – building the culture, finance, and strategic resources.
3. Market development and penetration – increase number of enrollees.

QUESTIONS FOR CLASS DISCUSSION

1. What are the unique problems associated with delivering health care to an indigent population?

- Patients face difficult priority choices, and health care often is not a top priority given the need for food, rent, and clothes.
- Historical reliance on safety-net-providers for health services and lack of knowledge about primary and preventive care.
- Limited transportation options to reach health care providers.
- Lack of familiarity with or understanding of concepts such as insurance and managed care.
- Low literacy levels.
- Physician extenders, although cost effective, are not valued by the patients as they are not “real” doctors.

2. What is the purpose and structure of the Community Care Plan?

CCP's purpose is to improve the health status of the community by:

- Improving access to care,
- Delivering more appropriate types of care (primary care services rather than ER services),
- Increasing continuity of care,
- Reducing the hospital's costs of delivering care to the indigent population, and
- Attracting more Medicaid, Medicare, and other “revenue” patients.

CCP's structure consists of:

- “Hub-and-spoke” network structure:
 - Non-physician providers at satellite clinics provide primary care services and serve as “gatekeepers;”
 - Specialty and inpatient referrals made to CGH (for adults) or Children's Hospital.
- Prepaid health plan for patients:
 - Annual membership fee (payable in installments);
 - \$2 co-payments for office visits; variable co-payments for other services and medications, based on income.
- Emphasis on disease prevention and health maintenance.

3. What are the factors that point to the need for change by Cooper Green Hospital?

- Revenue changes:
 - Balanced Budget Act and consequent changes in Medicare and Medicaid payment.
 - Challenges associated with the prospective payment system and movement toward capitation.

- Declining revenue from the Indigent Care Fund.
- Probability of the Disproportionate Share Hospital program being discontinued.
- End of funding from Robert Wood Johnson Foundation grant.
- Competition:
 - Because of financial pressures, competitors may more aggressively target Medicare and Medicaid populations as an ongoing source of revenue.
 - Competitors have more adaptive flexibility.
 - Increasing use of network structures among competitors (increasing consolidation).
 - Increasing managed care penetration.
 - Overbedding in the local market (12 area hospitals).
 - Threat of privatization of indigent health care.
- Shift in focus from inpatient care to outpatient care:
 - Driven by reimbursement changes.
 - Enabled by technological advancements.
- Customer changes:
 - One-third of Jefferson County's population is uninsured and the number is rising.
 - Health care is perceived as less important than crime, violence, housing, and drugs.
- Increase in aging population:
 - More of CGH's target population will be eligible for Medicare benefits.
 - Increase in chronic health conditions, requiring different types of care.

4. What factors constrain the hospital's flexibility -- its ability to adapt to changes in the external environment?

Its position within Jefferson County government:

- Not a separate operating authority.
- Subject to direct governmental oversight.
- Political concerns affect decision-making.
- Required to adhere to strict policies and job categories of the County's Personnel Board.
- Limited options for raising capital.
- Required to link the hospital's information system with the County system.
- Increased difficulty concerning "competing" with other health systems and the health department.

Organizational culture and image:

- Mindset of civil service employees.
- Administration has little leverage to overcome resistance to change.
- Difficult to punish or reward employees due to protections of civil service system.
- Lack of customer service orientation.
- Historical reputation as a "charity" or "poor people's" hospital.

5. What are the strengths and weaknesses of Cooper Green Hospital?

Strengths

- Visionary leadership.
- Low staff turnover; some staff are very dedicated.
- Good working relationship with Jefferson County Department of Health.
- Support from the Jefferson County Commission.
- Generally high satisfaction among patients.

Weaknesses

- Image, especially among those who have never used any services at CGH.
- Inadequate information system.
- Age and layout of the facility.
- Long waiting times.
- Limited and unstable funding.
- Lack of strategic flexibility.
- Organizational culture.

6. What are the strengths and weaknesses of the Community Care Plan?

Strengths

- Convenience for patients.
 - Satellite locations reduce transportation problems.
 - Shorter waiting times.
- Effective use of non-physician providers to deliver care.
 - Lower salary costs.
 - Well suited for primary care services.
- Enrollment growth in some clinics.
- CCP's employee culture.
 - High demand for jobs in CCP.
 - Customer service orientation.
 - Eager to innovate to serve patient population.
- Encourages prevention and health maintenance mindset among patients.
 - Improves health.
 - Reduces costs by reducing inappropriate utilization (ER visits, hospitalization).

Weaknesses

- Inadequate market research.
- Marketing implementation.
 - Lack of resources devoted to marketing.
 - Lack of awareness of CCP.
 - Reliance on complex written materials for population with low literacy skills.
- Clinics operating below break-even point.
- Lack of coordination and integration between CCP and CGH.
 - Information and billing systems.

- Awareness of CCP by hospital employees.
 - Lack of administrative resources.
 - Lack of its own HMO license.
7. Develop a strategic plan for Cooper Green Hospital and the Community Care Plan.

One class developed the following recommendations. Their suggestions are one approach; obviously, many others are possible.

These recommendations were developed within the following analytical framework:

Looking at Cooper Green Hospital as a whole, what organizational form would best serve the needs of the patient population and ensure the viability of the organization?

- Network model, or
- Hospital model

Based on the choice above, what should the adaptive strategy (expand, contract, or remain stable) for the CCP?

- Network model:
 - Stabilize the CCP, or
 - Expand the CCP
- Hospital model:
 - Contract the CCP, or
 - Close the CCP

How should the adaptive strategy be implemented?

What is the appropriate time frame? Should there be a multi-phase plan?

What strategic indicators or performance measures are associated with each phase?

What strategic tasks will need to be accomplished in each phase?

The class recommendations were as follows:

Organizational Form

- To remain viable in a rapidly changing health care environment and best serve the health care needs of its target populations, CGH must transform itself into a network configuration.
- To do this, CCP must become an integral part of the network, rather than a “sideline project.” The new network configuration should be based on the CCP model, with some modifications.
- Advantages:
 - Improved care,
 - Improved image,
 - Ability to compete for revenue patients.
- Risks:

Financial

- Capital needed to develop additional clinic sites.
- Capital needed to develop an information system.
- Operational expenses for clinical and administrative staff for satellite clinics.
- Operational expenses for marketing.

Political

- Reassigning and reducing staff.
- Appearance of competing with other providers, including Jefferson County Health Department.
- Patient resistance to changes.

- Two phases of implementation:

Phase I

- Begin transformation to network.
- Stabilize the CCP to “shore up” operational and marketing concerns.

Phase II

- Complete transformation to network model.
- Expand the CCP.

- **Phase I** (next 12 months)

Strategic objective:

- Begin transformation of CGH to a network model.
- Stabilize growth of CCP and “shore up” operational and marketing problems.

Strategic indicators:

- Two clinics at break-even point.
- Double rate of increase in enrollment in other clinics.

Strategic tasks:

- Conduct market research concerning CCP to determine –
 - What are levels of awareness among CGH patients and non-patients?
 - What educational/marketing approaches are best to reach the target population?
 - What factors determine attractiveness to patients and potential patients?
 - What factors detract from consideration of joining?
 - Where should clinics be located?
- Develop and plan heavy marketing and promotion –
 - Change image and identity from Cooper Green Hospital to Jefferson Health System:
 - Eliminate use of CGH name, logo, signage, letterhead, etc.
 - Eliminate use of CCP name, logo, signage, letterhead, etc.
 - Develop and use one logo for all Jefferson Health System operations.
 - Market internally to increase awareness and image among employees.

- Market externally to increase awareness in target population.
- Determine needs for complete IT integration and solicit proposals –
- Increase CCP administrative resources:
 - Add staff under Jerome Calhoun to handle workload,
 - Move Jerome Calhoun's office to main administrative suite, for both operational and symbolic reasons.
- Enlist support of JCC and Personnel Board for changes.
- Solicit support from physicians and community.
- Apply for HMO license.

All Phase I tasks require significant funding. For example, Dr. Michael estimated that the application process for an HMO would cost between \$750,000 and \$1 million and take considerable time. Students should have recommendations as to how these costs will be met. For example, a grant might be pursued for the HMO license but there aren't grants available for Marketing. Students in Marketing at UAB might develop marketing plans as part of a class project at no cost.

Other hospitals in the area and the health department might be formally pursued as "partners."

- **Phase II** (12 months to 36 months)

Strategic Objectives:

- Complete transformation to network model.
- Expand CCP (based on research from Phase I).

Strategic Indicators:

- Existing clinics should be at break-even point.
- 20% of patient visits are to be at satellite clinics by 24 months.
- 50% of patient visits are to be at satellite clinics by 36 months.

Strategic Tasks:

- Add target markets:
 - Working poor (more subsidized care).
 - Middle class with no insurance (accounts receivable will increase because of extended terms).
 - Non-poor Medicare (will they come to CGH?).
 - Insured (will they come to CGH?).
- Focus on outreach to local businesses for resources.
- Increase number of clinics; complete rollout by 36 months.
- Implement IT program.
- Promote HMO plan and cutback on FFS/HealthFirst.
- Divert services, resources to satellite clinics.
- Add/reassign administrative staff, as needed.
- Sustain marketing efforts, both internally and externally.
- Develop marketing plans for new target markets.

Summary of Recommendations (“take away points”)

- Transform CGH into a true network.
- Rename entire organization as Jefferson Health System; eliminate use of other names, logos, signs, letterhead, and so on.
- Make the CCP model an integral part of the network.
- Commit marketing resources essential for success of the network.
- Additional administrative staff needed to focus solely on satellite clinics.
- Develop comprehensive IT system for network model.
- Organizational culture must change:
 - embrace network model and resulting changes in operations,
 - develop more customer-service orientation,
 - reduce resistance to change; and
 - recognize that future changes will be needed to adapt to continuing change in environment.

CASE 15

US HealthSolutions

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 employee's 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 comprised 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.

This teaching note was written by Linda E. Swayne, The University of North Carolina at Charlotte. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission.

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 charge

STRATEGIC ALTERNATIVES

1. *Expansion/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/Alliance*. USHS can form an alliance with one or more major managed care organizations.
3. *Expansion/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 two 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 15/3) 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 capital 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 15/6 and 15/11):

- 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 15/7 and 15/12. 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 15/2 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).

Healthon/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, insurers, 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.

7. 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.

CASE 16

C. W. Williams Health Center: A Community Asset

OVERVIEW

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

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

KEY ISSUES

1. Rapid environmental change.
2. Community health center management.
3. Horizontal integration (geographic).
4. Strategic alliance with one hospital.

TEACHING OBJECTIVES

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

This teaching note was written by Linda E. Swayne, The University of North Carolina at Charlotte, and Peter M. Ginter, University of Alabama at Birmingham. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from Linda Swayne.

SUGGESTIONS FOR EFFECTIVE TEACHING

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

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

Your Presentation

1. Situational analysis.
 - External issues.
 - Internal issues.
 - Mission/vision (directional) issues.
2. Recommended C. W. Williams strategy.
 - What has to be fixed?
 - What should C. W. Williams do?
3. C. W. Williams as a part of a network.
 - Would you want C. W. Williams as a part of your network?
 - What role should it play?

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

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths

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

Weaknesses

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

Opportunities

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

Threats

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

STRATEGIC ALTERNATIVES

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

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

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

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

QUESTIONS FOR CLASS DISCUSSION

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

In 1966, an amendment to the Economic Opportunity Act formally established the Comprehensive Health Center Program. By 1990, more than 540 community and migrant health centers at 1,400 service sites had received federal grants totaling \$547 million. Community health centers have a public health perspective; however, they are similar to private practices staffed by physicians, nurses, and allied health professionals. They differ from the typical medical office in that they offer a broader range of services, such as social services and health education. In addition, centers are typically owned by the community and operated by volunteer governing boards.

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

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

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

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

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

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

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

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

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

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

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

Perhaps there are two approaches – aggressive or passive. The aggressive approach suggests aggressively entering into agreements to be a part of a system of care (even with Carolinas

Medical Center). The passive approach suggests seeing how things “shake out” in the Medicaid system currently being developed.

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

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

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

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

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

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

If the students are involved in the case, they typically are very strong in their reactions. The Board comprises at least 51 percent C. W. Williams patients – often uneducated and out of the workforce. Ms. Marrs has an educational task to teach these board members what their responsibilities are and are not. Ultimately, she has to put her job on the line if she wants to be effective: “Set the policies and judge my performance in carrying out those policies. If I’m not performing my job the way that I should, find someone else.” Her duties and those of the board are clearly specified in the articles of incorporation and bylaws. The Board needs to understand the difference between setting policy and meddling.

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

Situational Analysis

1. Two emerging systems, both diverse, with ambulatory, hospital, and insurance components.
2. C. W. Williams needs to align with a hospital system.
3. Most physicians are employed by a hospital system or have managed care contracts.
4. Hospitals need to align with C. W. Williams to prevent primary care in the emergency room.
5. Medicaid population is being channeled into managed care protocols.
6. Strong Kaiser health plan.
7. Consumers have greater choice in referral network.
8. Potential disenrollment is quite high (six-month recertification process).

Internal Issues

Strengths:

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

Weaknesses:

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

What Needs to Be Fixed

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

Network

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

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

Role

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

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