CASE 17

Regional Memorial's Institutional Ethics Committee: Work To Do

OVERVIEW

Mr. Blackwell consulted the Institutional Ethics Committee (IEC) of Regional Memorial Hospital. The IEC, an interdisciplinary group, provided advice concerning pressing ethical problems that arose in clinical care and ethical problems that had bearing on health care to assist decision makers in reaching better conclusions. His concerns centered around four situations that had plagued his medical and administrative staffs for months. The clinical cases of Baby Boy-X and Annie O. were not typical, but they raised ethical issues that were troublesome, fairly common, and not easily managed. In addition, the issues found in the baby formula situation and the vendor ethics question generated conflicts among staff and, if made public, could cause adverse publicity. These four cases presented some tough ethical and community health issues.

Baby Boy-X was born at thirty-six weeks gestation with a lengthy list of serious problems. The consensus among the neonatal intensive care unit (NICU) personnel was that the prognosis was poor and they expected the patient to die from a massive infection or following violent seizure activity. On numerous occasions, members of the medical and administrative staffs initiated discussions with the mother about her son's grim prognosis and poor quality of life. They believed that the patient would never leave the hospital alive and his life in the hospital was severely compromised and painful. However, the mother continually insisted that everything medically possible should be done for her child.

Annie O. was a 41-year-old female who was hospitalized 41 times over a period of three years. The hospitalizations ranged from 4 to 21 days. She was a wheelchair-bound paraplegic with a variety of problems (including being pregnant) and lived in poor conditions. In addition, she was rude, hostile, and self-destructive. Her uncooperative attitude and risky lifestyle made her case extremely difficult to manage.

The baby formula case involved the practice in three area hospitals of giving new mothers free baby formula supplied by manufacturers. "Gifts" of formula were made despite health professionals' generally united belief that breast milk was best for infants. Four strategies were generated to deal with this apparent conflict. They were: (a) accept no free formula at all; (b) give no free formula to breast-feeding mothers; (c) charge patients a fee for the formula; and (d) give the formula to the patients, but include information about the advantages of breast feeding.

The vendor ethics case involved a middle manager in the hospital and a landscaping contract. Blackwell discovered that the manager had accepted a gift of several ornamental cherry trees from a company involved in a competitive bid for a hospital contract. The manager, who was an able and trusted employee of long standing, argued that the conflict of interest was only

This teaching note was written by John M. Lincourt, 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.

apparent. Her recommendation to the CEO about the contract transcended the gift of the trees and was judged solely on the respective merits of the proposals. She claimed the best company won the bid and the gift of trees was merely coincidental.

KEY ISSUES

1. The cost of care for extremely high-risk cases.
2. Providing care when the efficacy of any type of care was questionable.
3. What constitutes a fair level of care in "hopeless" cases?
4. Conflicts of interest involving hospital practices.
5. Ethical issues involving employees and institutional policy.
6. Issues of trust and integrity.
7. Biomedical issues often have an administrative component.

TEACHING OBJECTIVES

1. To demonstrate the types of ethical decisions leaders may face.
2. To show that ethical issues are of major importance in health care settings.
3. To show how institutional ethics committees may be used by an administrator to clarify issues, increase awareness of and sensitivity to ethical issues, and help generate policy regarding ethical concerns.
4. To point out potential problems and controversies that arise with institutional ethics committees and different institutional approaches.

SUGGESTIONS FOR EFFECTIVE TEACHING

The following approaches have been used effectively in teaching the case:

1. In working through the case, it is best to employ a standard logic module. Useful examples can be found in S. Toulmin, R. Rieke, and A. Janik, *An Introduction to Reasoning*, 2nd edn (New York: Macmillan and Company, 1984) and John Lincourt, *Ethics Without a Net: A Case Workbook in Bioethics*, 2nd edn (Dubuque: Kendall/Hunt, 1995).
2. Invite guest speakers such as the chair of the hospital IEC, a hospital trustee, a physician, a nurse administrator, Hospice official, public health officer, or a professional ethicist from an ethics center or local college or university to listen to the students' discussion and then react to it.
3. Invite a health administrator from another institution to lead a discussion of the case by providing a workable solution and ethical justification for his home institution.
4. Make arrangements for the class to visit a local health care facility's neonatal intensive care unit or emergency room.
5. Review policy manuals from several health care institutions to determine their success in managing ethics cases involving conflicts of interest. Design a workable ethics policy involving conflicts of interest for a health care facility of your choice.

6. Along with the text, request that students purchase several overhead transparencies and a water-soluble pen for in-class case presentations. To prepare the case, each student writes his or her analysis on the transparencies and should be prepared to lead the class discussion on one of the situations by projecting what is written on the transparency. Four different students may be called on to present their analysis for one of the issues.
7. Divide the class into groups of five to seven students and ask them to assume the role of an institutional ethics committee member. Ask their advice and recommendations on an ethically defensible course of action.
8. Refer students to the extensive secondary literature in bioethics. One useful resource for managers in health care is *The Hastings Center Report*.

QUESTIONS FOR CLASS DISCUSSION

1. What ethical issue is involved with Baby Boy-X? Annie O.? Providing free baby formula? With the manager's decision regarding vendors?

- *Baby Boy-X* – Prolongation of suffering.
- *Annie O.* – Non-compliance and the right to health care.
- *Free Baby Formula* — What is best for infants versus perceptions that the hospital has given a free gift and future profits for formula manufacturers.
- *Vendor Decision* — The apparent conflict between the personal interests of a manager and an apparent vendor advantage.

2. What questions would you want to answer about the ethical issue?

- *Baby Boy-X* – Should the heroic measures the child is receiving be stopped and palliative care be introduced until the child dies naturally?
- *Annie O.* – What role, if any, should Annie O.'s non-compliant behavior and lifestyle play in the health care provider's duty to provide care for the patient?
- *Free Baby Formula* – Should hospitals adopt or continue the practice of giving free baby formula to new mothers, especially in families where the future costs of the formula would be prohibitive? Is the issue of future profits for formula manufacturers relevant?
- *Vendor Ethics* – Should managers be prohibited from accepting or giving gifts, favors, or gratuities to parties with whom a manager does business?

3. What are plausible answers to the question?

Baby Boy-X

- Preserving life at all costs is a solemn moral obligation without exceptions. Heroic measures must continue.

- The sanctity of life argument can be superseded in the event that medical interventions are futile, produce suffering, and only postpone the moment of death (quality of life argument).
- The child should be allowed to die naturally and quickly, especially if the resources needed to keep the child alive are extensive and could be redirected to bring about a greater social good.

Annie O.

- No role – entitlements in health care should be based primarily on need not merit.
- Large role – the patient's unwillingness to follow medical orders and lifestyle are sufficient justification to reduce or cancel her right to access health care resources.
- Some role – the patient is entitled to some level of care regardless of her behavior and lifestyle choices. Precisely what level is open to question.

Free Baby Formula

- Hospitals and patients should pay for baby formula. In many cases, it is an unnecessary expense, since breastfeeding is a real option. Breastfeeding information should be readily available especially for first-time mothers.
- Free baby formula should be given only to indigent mothers who repeatedly fail at breastfeeding. All others should pay the market price.
- Patient and hospital autonomy should be respected. No one should interfere in what a patient freely chooses to do and what services a hospital wishes to provide.

Vendor Ethics

- Gratuities in any form should not be accepted by persons directly involved in the business decision.
- Gratuities may be accepted but should be distributed by lottery. They should not be earmarked for specific employees nor solicited by them.
- Gratuities should be banned entirely. This includes small items such as pens and doughnuts.
- Gratuities are correct if they do not affect the decision maker.

4. What is your answer? Accompany your answer with reasons that justify it and make it demonstratively more acceptable that the alternative answers.

- *Baby Boy-X* (Sample student answer): Baby Boy-X should be allowed a natural death outside the intensive care setting. If possible, a hospital ethics committee should be consulted for advice and support.
- *Annie O.* (Sample student answer): Annie O. is entitled to a minimal level of health care. This would include those interventions that would thwart life-threatening situations. Interventions to reduce or eliminate pain and discomfort would not be included.
- *Free Baby Formula* (Sample student answer): All patients should pay the full market price for baby formula. Formula should be viewed as a luxury and not an entitlement.

- *Vendor Ethics* (Sample student answer): Gratuities in any form should be strongly discouraged. A policy to that effect should be enacted and exceptions should be reviewed by an appropriate oversight committee.

5. What are the major counter arguments? This refers to a set of circumstances under which you would abandon your own argument. Identify the counter argument and gauge its strength and plausibility.

- *Baby Boy-X* – This argument should be abandoned if the child displays massive and continued improvement or goes into remission.
- *Annie O.* – If it can be shown conclusively that the patient's choices were determined by factors beyond her control, her culpability would be lessened. She would then be a victim of circumstances and the claim regarding what she is entitled to would have to be reexamined.
- *Free Baby Formula* — The formula manufacturer agrees to supply all future formula needs to indigent mothers free of charge and not pass those costs along to other formula users.
- *Vendor Ethics* — The argument should be abandoned if the manager could show that the gift of trees did not affect her recommendation (for instance, a blind review process was used).

6. Having reviewed the counter argument, should you abandon your position? If not, devise a strategy to defeat or weaken the counter argument.

- *Baby Boy-X* – The plausibility of the counter argument is low. Miraculous cures and reversals of terminal illness do occur but are extremely rare and cannot be counted on to happen. They can also be the source of considerable suffering because of groundless hope.
- *Annie O.* – The particulars of the case do not support the counter argument and her choices appear to be largely the direct result of her voluntary assent. Abandoning the argument would be improbable.
- *Free Baby Formula* — The counter argument tends to run against the standard business practice of cost shifting in such cases. At best, the counter argument would be in use over the short term.
- *Vendor Ethics* — This is a plausible argument. It would require clear and compelling evidence for reciprocity without hidden agendas. It would also require monitoring to ensure compliance. In the case of high-ranking managers, this may be a difficult practice to initiate or verify.

EPILOGUE

The Actual Decision, Baby Boy-X
NICU personnel continued to engage the mother in discussions about her son's condition and prognosis but to no avail. The patient had developed a bilateral pneumonia and was being treated

aggressively with antibiotics. NICU nursing staff became openly critical of the attending physicians for allegedly using a "dodge technique to avoid litigation." There was little doubt that staff morale had been impacted negatively by the apparent contradiction between the dire prognosis and the aggressive care plan.

In an attempt to break the deadlock, a social worker, nurse, and medical resident drove to the patient's hometown in search of his father. At first, the father was reluctant to discuss the matter, let alone get involved. He later agreed to visit his son in the NICU and discuss the care plan. He became very upset on seeing the child the first time. He returned several days later to discuss the child's status and the possibilities for a normal lifespan. Several days later, the father consented to have the child moved to a regular pediatrics floor. The mother offered no objections. The child was given medications to help him sleep and the antibiotic protocol was discontinued. Baby Boy-X died ten days later of respiratory insufficiency secondary to pneumonia.

The Actual Decision, Annie O.
Annie was much sicker on this admission than most people initially thought. Her hospitalization lasted well over a month, before she was healthy enough to be discharged. Due to her diabetes and other factors, her pregnancy was classified as "high risk." She miscarried midway through her third month of pregnancy. In an attempt to break the cycle of re-infection due to unsanitary living conditions, a social worker from Regional Memorial contacted the farmer with a strange request. On hearing the rationale, the farmer agreed to burn his garage to the ground. Social Services then made arrangements for Annie to live in a public housing project near the hospital. On hearing the new developments in her housing situation, Annie was uncharacteristically compliant. She indicated she was not happy with the arrangement, but had little choice. To summarize the justification for the recent steps in the Annie O. case, one health care provider put it this way: "As professionals, we owe Annie some level of safety and treatment, but we do not owe Annie happiness." The patient moved out of the housing project about six months later and was lost to follow up.

The Actual Decision, Baby Formula
At Mr. Blackwell's request, the IEC of Regional Memorial Hospital met to advise him on a morally justifiable course of action relative to the hospital's free baby formula practice. The IEC advised Blackwell to adopt option (1) as official hospital policy (provide no free baby formula at all). Although the practice of providing free formula may be perceived as a kind gesture, the IEC questioned whether it was in the long-term best interest of the infants. They argued that if the hospital paid for its baby formula, hospital personnel would work harder to encourage and help more women to breast feed. The other two hospitals in the area continued the practice of giving away free formula to mothers along with information about the benefits of breastfeeding. The short hospital stays under current managed care plans make breastfeeding orientation of new mothers even more susceptible to outside marketing practices.

The Actual Decision, Vendor Ethics
The IEC advised Blackwell to follow the lead of another hospital in the region in dealing with questions involving vendor ethics. In this institution, the ethics committee and executive staff

became so concerned that they developed and adopted a specific policy on hospital/vendor relations. The policy included an important guiding principle. It stated:

> *Employees should not accept any gifts, favors, or hospitality that would lead a reasonable person to believe that such activities might influence their decisions or actions affecting the corporation.*[1]

This principle serves as the justification for several operational directives involving vendors, employees, and departments. These include disallowing any gifts or cash to individuals plus the not-so-subtle practice among some employees of soliciting vendors directly for gifts and favors. One exception deserves mention. Some forms of gratuities such as free breakfasts or lunches that may strengthen vendor relations with the institution are permitted, if there is some way to reciprocate at the employee or department's expense. Finally, hospital executives recognize that every situation involving vendor-employee relations is not covered by this policy and new situations will undoubtedly arise as the health care environment shifts and changes. For unclear or disputed questions, the hospital established a Conflict of Interest Guidance Committee. The purpose of the committee is advisory only; the final decision rests with the employee or department.

NOTES

[1] "Addendum to the Conflict of Interest Policy," *Administrative Policy and Procedure Manual* (September 1993) I-D-3, p. 1. I am indebted to Mr. Paul Betzold, President and CEO, and Mr. Roger Simpson, Department of Human Resources, of Presbyterian Hospital, Charlotte, NC for their assistance on policy and practical matters associated with vendor ethics in health care.

CASE 18

The *Premier* Health Care Alliance Emerges

OVERVIEW

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

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

KEY ISSUES

1. Proper organizational structure for the new Premier alliance.
2. Encouraging member partners to purchase more goods and services.
3. Survival of alliances as hospitals become involved in networks and develop purchasing power without using alliances.
4. Strategic direction for an organization in a mature industry.
5. The challenges of leading a volunteer organization with over 350 "bosses."
6. Premier's positioning in the hospital alliance market.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Develop and defend a strategy to the ownership group of a "voluntary" alliance.
2. Understand that not all growth is desirable.
3. Develop strategy for an organization that has successfully completed a major merger but now has to reinvent itself as a new organization.
4. Understand that all types of health care organizations are being affected by significant environmental change.

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.

SUGGESTIONS FOR EFFECTIVE TEACHING

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

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

EXHIBIT 18/7: Comparison of AmHS, Premier, and Sun Health

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

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

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

Strengths	Weaknesses
1. Largest hospital alliance.	1. Diversity of mission, vision, and values of the three merging organizations.
2. Group purchasing power.	2. Organizational cultures not yet merged.
3. Financially strong.	3. Redundancy of services offered across the three organizations.
4. Reputation for quality services.	4. Voluntary organization, little allegiance.
5. Visionary leadership.	5. Slowness in decision-making; policy changes have to be approved by the Board.
Opportunities	**Threats**
1. Health care reform.	1. Health care reform.
2. Continued business and public pressure for cost containment.	2. Emergence of new competitive format (integrated delivery systems).
3. Aging of American population.	3. Competitive national alliances (VHA).
4. Continued escalation of technology.	4. Competition among hospitals limits potential new partners in any given market.
	5. Many independent hospitals belong to more than one purchasing group.
	6. Industry consolidation.

STRATEGIC ALTERNATIVES

Adaptive Strategies:

1. *Expansion/Market Development* – some areas of the country are not served by Premier or different health care organizations, target markets, or market segments could be included.
2. *Expansion/Product Development* – building healthy communities requires some new products that are less well identified by hospitals.
3. *Expansion Penetration* – stimulate current members to do more purchasing from Premier because of lower prices.
4. *Maintenance of Scope Enhancement* – improve service.

Market Entry Strategies:

1. *Cooperation/Joint Ventures* – pursue new ways to cooperate with member hospitals or hospitals with each other or with different health care organizations.
2. *Internal development/Service Area Expansion* – target geographic areas or segments that are unserved.
3. *Internal development/New Products* – determine members' needs for the future.

QUESTIONS FOR CLASS DISCUSSION

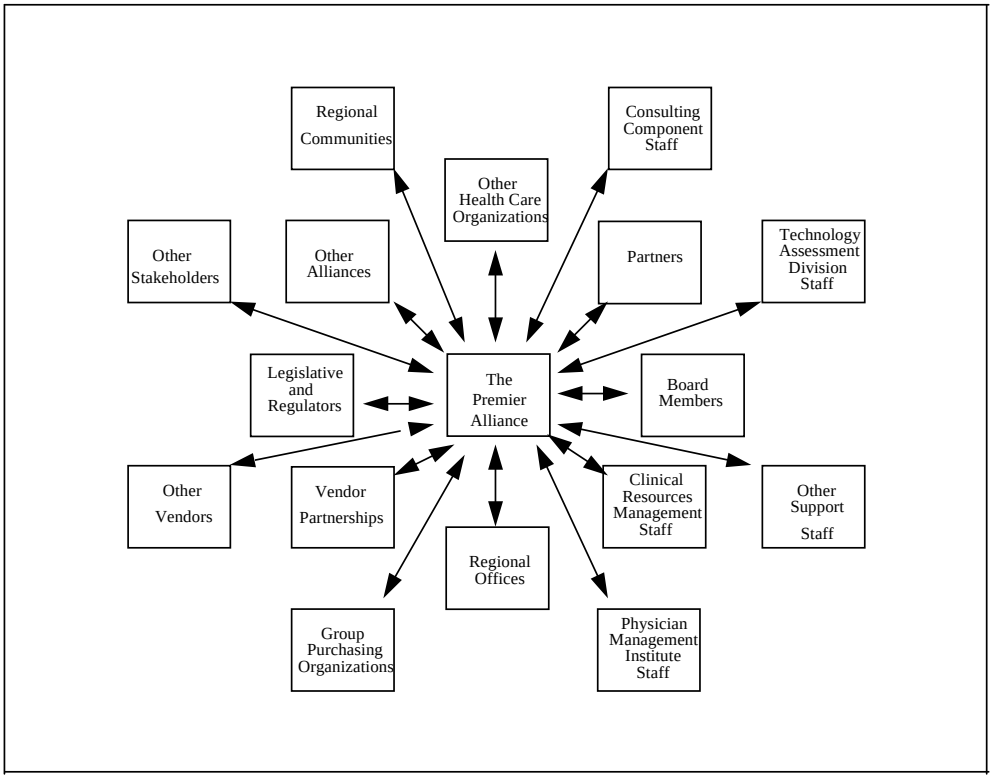
1. Are hospital alliances becoming dinosaurs in the health care industry?

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

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

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

Stakeholder Map for Premier Alliance



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

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

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

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

four strategic postures – aggressive, competitive, conservative, and defensive. The quadrant with the largest area is suggested as the most appropriate general strategic position. The individual factors are evaluated for the Premier Alliance under the definitions of the four dimensions below.

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

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

Average Score = 3.9

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

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

Average Score = 4.0

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

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

Price Elasticity of Demand	Elastic	0	1	②	3	4	5	6	Inelastic

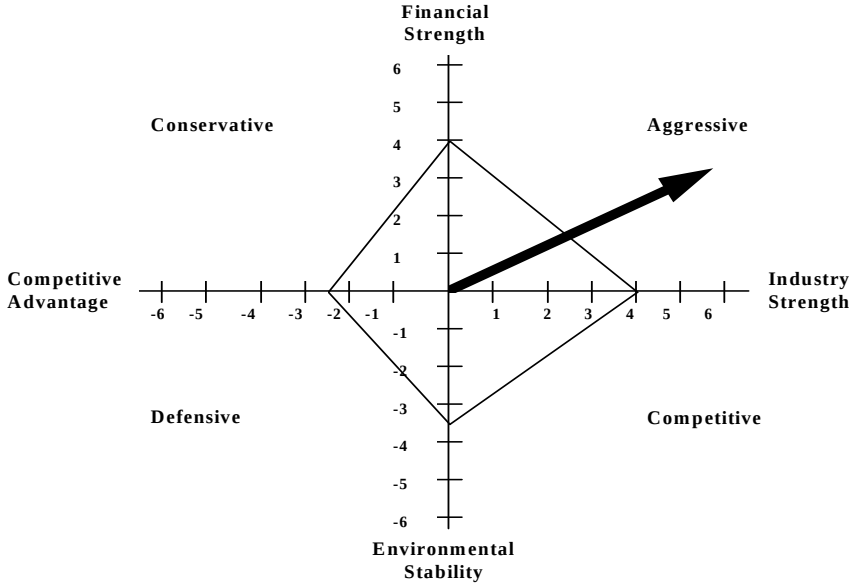
Average Score =
(–6) + (2.4) = –3.6

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

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

Average Score =
(–6) + (3.5) = –2.5

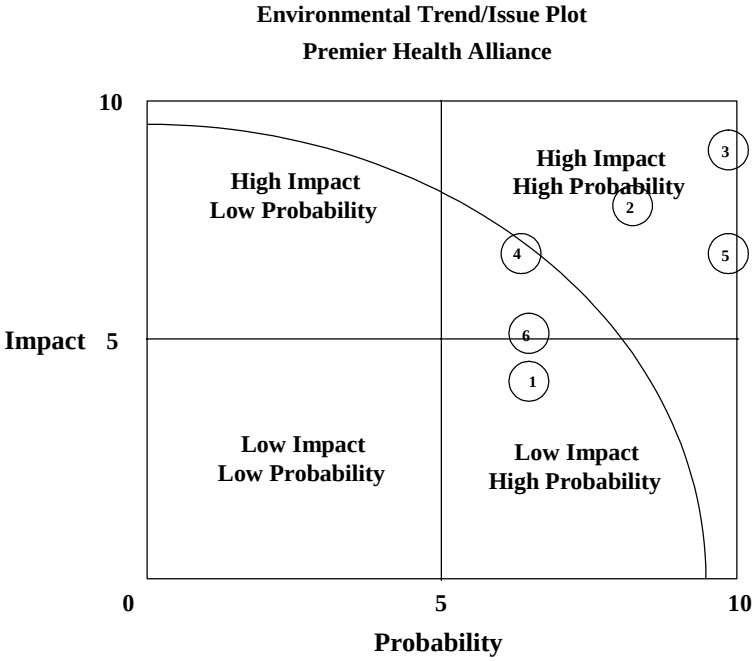
SPACE Diagram for Premier Alliance



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

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

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



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

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

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

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

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

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

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

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

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

Strategic control is particularly difficult for a voluntary alliance because there has to be reasonable consensus on the mission, vision, values, and goals. Thus, it is likely that many do not agree with all aspects of the organization's direction and strategies for achieving it. Each

member organization knows everything about Premier, but Premier only knows what the members want it to know about their individual organizations. Therefore, it is challenging to set objectives, measure performance, and correct for deviations. In addition, Premier negotiates prices for the alliance partners but does not warehouse or inventory the items. Premier has to wait for reports from the vendors to know how much purchasing has actually been done by members. As a result, they have to try to correct for deviations considerably after the fact.

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

- First, and most important, Premier must satisfy current members so well that when organizations merge the member advocates maintaining association with Premier rather than the alliance of the other organization(s).
- Second, Premier has to increase its clout with group purchasing so that the products and services it offers to members are at excellent prices. The merger was sold to the three organizations on the basis of improved purchasing abilities.
- Third, Premier has to reinforce its image of being much more than a group purchasing organization. Its consulting services must be first rate with expertise in the most recent developments in health care policy, technology, and so on.
- Fourth, integrated networks are going to continue to expand and will include more than hospitals. Physicians, out patient facilities, sub acute care facilities, long-term care facilities, and others will no doubt become "integrated." Hospitals are leading the way, however these other health care providers will need purchasing and consulting services. Premier is on the right track with the Physicians Management Institute.
- Fifth, Premier must work to develop strong personal ties so that members feel responsibility and obligation to the "fraternity" of Premier members. This is probably the most difficult goal for any voluntary alliance.
- Lastly, Premier needs to develop real expertise in capitated contracts. Now may be the right time to offer a risk product.

CASE 19

The Case for Open Heart Surgery at Cabarrus Memorial Hospital

OVERVIEW

Cabarrus Memorial Hospital (CMH), a private not-for-profit hospital located one half hour northeast of Charlotte, North Carolina, was planning for the anticipated rapid growth of the region. Kannapolis, in northern Cabarrus County, was the home of Cannon Mills, the world leader in bed and bath textile products. Mr. C .A. Cannon, son of the company's founder, had been responsible for the growth and magnitude of the company. With his support, Cannon Mills had invested heavily in health care for its 35,000 employees through CMH. In addition, Mr. Cannon had assisted in initiating a strong affiliation between Duke University Medical Center and CMH.

With money from various trusts and endowments from the Cannon family, there were resources designated and available to CMH for growth and updating of capabilities. The board of trustees, a cross-section of the area's executive leadership, was faced with a strategic decision regarding the development of a comprehensive heart program. Dr. Ralph (Chris) Christy had served on the medical staff and left for a fellowship in cardio-thoracic surgery. He had expressed an interest in returning to CMH to begin a medical practice in this specialty. The board did not want to lose Dr. Christy to another medical facility for a number of reasons. However, was the market large enough to support Dr. Christy? Would people stay in Cabarrus County rather than going to other hospitals for cardiac problems?

KEY ISSUES

1. Health care service area analysis and planning.
2. Market analysis for a new service.
3. Financial analysis for a go/no-go decision on a new service.
4. Government regulation and certificates of need (CON).
5. Governance.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Determine the number of cases needed for a successful new service.
2. Understand that service area changes by service category.

This teaching note was written by Fred H. Campbell, The University of North Carolina at Charlotte, and Darise D. Caldwell, Executive Vice President and Chief Operating Officer, Northeast Medical Center. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

3. Understand that other functional areas impact marketing decision making.
4. Apply market analysis and competitive forces analysis in health care marketing.
5. Use strategic thinking skills to make a decision as to whether the hospital should offer Dr. Christy a position and offer cardiovascular surgery services.

INTENDED COURSES/AUDIENCE

This case is appropriate for use in graduate and advanced undergraduate courses in Health Care Management, Health Care Strategy and Marketing, and Business Strategy. Additionally, it could be used effectively in continuing education or management training courses for health care management professionals.

SUGGESTIONS FOR EFFECTIVE TEACHING

The CMH case is a real organization and real people (no disguised names). However, since the time of the case, CMH has changed its name.

In January 2005, approximately 37 states required Certificates of Need (CON) prior to the expenditure of threshold amounts of money for the addition of health care equipment and facilities. Some states cover hospitals, physician practices, long-term care, and so on although other states cover only specific components of the health care system. Some states are contemplating repeal of CON laws whereas others are anticipating strengthening CON laws. The CON issue has been much discussed in health care circles and continues to be somewhat controversial. An assigned question could be, "Are CON's a good way of controlling health care costs or do they inhibit competition?"

Depending on the importance of CONs in the instructor's state, he or she may want to duplicate and hand out Appendix A in this Note. Alternatively, students may be asked to research CONs for the state in which they currently reside.

In addition to states being involved with licensing and CON requirements, the federal government plays a major role through the administration of Medicare. For non-health care students this may not necessarily be a consideration but health care students should readily be aware of these forces.

As you lead the discussion of the case keep these questions in mind. What are the driving forces in the decision? Should the Board be influenced by the time pressure apparently imposed by Dr. Christy or should the decision be market driven? What are the competitive forces in play?

Financial considerations are important primarily because of the way the state will look at expenditures in its review of the CON application. It is apparent that CMH is financially strong and can easily meet the financial obligations with a "go ahead" decision. Regardless, students should look at the financial information to determine if it appears feasible based on market information (expected demand).

One way to start the class discussion is to ask students, "How would you define the problem faced by the CMH Board of Trustees?"

QUESTIONS FOR CLASS DISCUSSION

1. Does the proposed program comply with the hospital's mission?

Yes. The hospital's mission statement adopted by the board took CMH beyond the role of a typical primary care community hospital. Included in the mission statement was a clause that stated, "CMH will be a comprehensive provider of health care with hospital/clinical care, home health, medical education and medical research."

2. Does CMH have sufficient infrastructure and financial resources/leverage necessary to add the program?

Yes. Not only had CMH developed a strong professional management team and professional staff but it had adequate financial resources. Exhibits 19/13 and 19/14 in the text demonstrate the level of staffing. The hospital had no debt and sufficient cash reserves for funding the plan.

3. What is the competitive situation among other area hospitals that could impact the decision? Would they offer competition or cooperation to CMH?

The competitive situation presented a challenge to CMH because any attempt to attract patients from a larger service area would be seen as a threat by surrounding hospitals. The large Charlotte hospitals are not likely to get approval to physically enter the CMH service area with competitive facilities, but it is feasible that they could form alliances with the smaller competing hospitals in Rowan and Stanly counties thus thwarting CMH's chances of success. For example, the large Charlotte hospitals could provide onsite cardiology support and referrals or institute mobile intensive care transport systems to bring patients from the smaller hospitals to Charlotte bypassing CMH. Be sure to encourage the students to consider all the competitive forces, real and potential. What contingency plans should CMH have in place should the competition become a real player in success or failure? Initially, local competitors fought the CMH attempt to gain a CON but were unsuccessful in their opposition.

4. Is the hospital's proximity to Charlotte an advantage or disadvantage? What about its affiliation with Duke University Medical Center?

It is an advantage in the sense that CMH profited from the growth of the region spawned by Charlotte. The Duke affiliation was definitely an advantage. Not only did this affiliation provide excellent continuing medical education but also supplied nationally recognized expert consultation to the heart program.

5. What is the break-even number of cases for the cardio-vascular program at CMH?

The following is a simple break-even analysis based on information in the case:

COSTS (from Exhibit 19/14)

Direct costs in year 1:	$2,364,214
Indirect costs in year 1:	$503,650
Total costs in year 1:	$2,867,864

REVENUE

Room and board:	$826 × 9 days average stay =	$7,434
Ancillary charges:	$3,725 × 9 days average stay =	$33,525

Revenue per case = $7,434
+33,525
$40,959 Total revenue per case

Break-even for year 1 would be $2,867,864 divided by $40,959 or 70 cases per year.

6. How much change in the service area would be required for the cardio-vascular surgery service?

The hospital administration, after a review of national data, determined that a service area of 200,000 people was necessary for success. Accordingly, the adjoining areas of surrounding counties had to be considered as part of a broader service area. As seen from case data, the existing population in the proposed service area of Cabarrus, Rowan, and Stanly Counties would offer a population base of over 260,000 people.

7. If the threshold population required for initiation of the program proved adequate what were the financial obligations and obstacles to success?

Interestingly, CMH had never used any long-term debt thus when the board explored contingency sources of credit they found CMH had no credit rating because it had no credit history. This was not a problem with the assistance of the Cannon Foundation and hospital cash reserves. No borrowing was necessary.

8. Discuss the pros of states requiring certificates of need to permit hospitals adding facilities and equipment.

Although the premise is that CONs restrict excessive spending for health care construction and capital equipment, this question should generate discussion about health care market competition and the role of government regulation. Discussion may vary based on the state in which the students/university are located and the prevailing CON laws.

9. Could a certificate of need (CON) be obtained from the State of North Carolina to build and expand the hospital's heart capabilities?

Although there was resistance from competing hospitals, with the strong support of the local community and the effective documentation of program need in the CON application, the CON was approved.

10. Are there any other factors or concerns that could impact the board's decision?

There were no further obstacles to proceed with the proposal. The market data proved sufficient. CMH had the infrastructure and financial resources, and a qualified cardio-vascular surgeon in the person of Dr. Christy. A specialized supporting staff was available along with initial support from Duke.

11. What alternative strategies should the Board consider before making a "go/no-go" decision on the possible addition of the open heart program?

Service line strategic decisions should be considered. Consideration should be given to other service line investments such as cancer treatment. Which service category offers better chances for CMH to differentiate itself?

12. Should CMH offer comprehensive cardiac care?

Yes. The service area is adequate to produce at the B/E or above. The hospital can afford it and an excellent home-grown MD will head it. All indications are positive.

EPILOGUE

CMH made the decision to go ahead with the heart program and it proved to be very successful. The service area experienced rapid growth in part because of its proximity to Charlotte. CMH was successful in drawing patients across county lines. However, there was some competitive resistance from area hospitals. Rowan Memorial in Salisbury and Stanly Memorial in Albemarle evidently saw this move by CMH as a competitive threat. Rowan formed an alliance with Presbyterian Hospital in Charlotte whereby Presbyterian actually used a mobile cardiac intensive care unit to transport patients from Rowan Memorial if they were in critical condition or needed advanced treatment such as cardio-vascular surgery. Stanly Memorial formed an alliance with Mercy Hospital in Charlotte, a division of Carolinas Medical Center. Mercy actually placed cardiologists on-site at Stanly and referred many patients back to Charlotte-based Mercy. However, the cardiology group based at CMH was able to move into Stanly and essentially took over its heart program. Referrals began going to CMH. The patients and their families resisted going to Charlotte and the CMH cardiologists did a good job of winning over the Stanly hospital staff and community.

In the first full year of the heart program there were 206 cardiovascular operating room cases. In the second year there were 292 cases and in the third year there were 318.

During the second year an additional cardio-vascular surgeon, Dr. Medhat Takla joined Dr. Christy's practice. Subsequently a third cardio-vascular surgeon, Dr. Christopher Cici joined the practice.

Not only did CMH proceed with the proposed heart program, the board named the heart center "The Cannon Heart Center" in appreciation for the long-standing support from the Cannon family and the Cannon Foundation. Furthermore, various health care monitoring and reporting agencies gave CMH's cardiac program the region's highest ratings in cardiovascular operating room outcomes even when the cases were severity adjusted.

Appendix A
Certificate of Need:
State of North Carolina

The following are Findings of Fact as set forth in North Carolina General Statute 131E-175.

The general assembly of North Carolina makes the following findings:

1. That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed components of these health service facilities.
2. That the increasing cost of health care services offered through health service facilities threatens the health and welfare of the citizens of this State in that citizens need assurance of economical and readily available health care.
3. That, if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.
    a. That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process.
4. That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilitization of health care services.
5. Repealed by Session Laws 1987, c.511, s.1.
6. That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.
7. That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served.

At the time of the case, health care organizations with planned expenditures of $750,000 or more would have to apply for and receive a CON for approval to proceed.

C A S E 20

Sunshine County Health Department: Strategy Implementation

OVERVIEW

The staff of Sunshine County Health Department (SCHD) had concerns about patient waiting times, length of time to get an actual appointment, and overall patient flow issues in the medical and dental divisions. The senior staff proposed to use open access scheduling rather than the current unsatisfactory method of scheduling, whereby patients had to wait weeks or months to be seen for an appointment.

SCHD was located in a rapidly growing community that had grown ten percent per year since 2000. Twenty percent of the population were Medicaid recipients, and many of these Medicaid recipients received care at SCHD. The staff had wanted to do a patient flow analysis to determine the causes of their problems. Consultants had proposed using a strategic flow management model to assist the staff in their evaluation, rather than using a single technique of patient flow analysis. Ms. Rogers, the new Administrator for SCHD, saw many opportunities to improve not only the ailing dental and medical divisions, but to make other positive changes at the health department to meet the community's needs.

KEY ISSUES

1. Rapid population increase.
2. High population (20%) of Medicaid recipients.
3. Patient flow bottlenecks.
4. Unsatisfactory method of scheduling patients.
5. Application of a strategic flow management model that could provide information to develop value adding service strategies.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Perform an internal analysis of an organization using the TOWS matrix.
2. Determine the needs of an organization focusing on an operations management perspective.
3. Determine capacity or demand management relative to patient flow.
4. Understand both the necessity and the complexity of applying the strategic model of flow management to an organization.
5. Develop value adding service delivery strategies at the point of service.

This teaching note was prepared by Donna Malvey and Eileen Hamby of the University of Central Florida. It is intended to be used as a basis for class discussion rather than to illustrate effective or ineffective handling of an administrative situation. This work is based on research funded by the IBM Center for Healthcare Management. The opinions and conclusions expressed herein are entirely those of the authors. Used with permission from Eileen Hamby and Donna Malvey.

SUGGESTIONS FOR EFFECTIVE TEACHING

It is suggested that the class be divided into teams of four to five people who will analyze this case. The case analysis should follow the guidelines for performing a case analysis located in Appendix A of the text. Students can be required to look at the difference in information a patient flow analysis would provide versus using the more comprehensive strategic flow management model to perform the analysis. This method provides the students an opportunity to evaluate the big picture and to understand that problem issues are not usually in isolation. A patient flow analysis only would have demonstrated how patients moved through the system, but a look at policies and procedures, revenues and expenses, job descriptions, facility layout, human resource issues, and so on, provided additional required information that allows the student to see the benefit of not looking at issues in a vacuum. It also has the student look at non-traditional opportunities for solving problems. In this case, open access scheduling is looked at as one component that can assist in solving the SCHD dilemma. This case provides a lesson to students in realizing that things are not always what they seem to be. The employees at the health department felt that they were overworked and that expansion of the facility's physical structure was imperative. They also thought that they needed more staff.

After looking at productivity and the other areas of the strategic flow management model, it became apparent that the health department had adequate space and resources. What was lacking was effective operations management, plus there was a lack of point-of-service value adding service delivery strategies. Each team will make a presentation on its own case findings. Then they will perform a comparative analysis with other teams on their findings and have a discussion among all teams on what point-of-service value adding service delivery strategies they would implement for SCHD, and why.

QUESTIONS FOR CLASS DISCUSSION

1. What are the main conclusions of this case?

The results of the internal analysis combined with the results of the strategic flow management analysis presented a comprehensive picture for decision-making regarding further strategies. For example, the internal analysis revealed scheduling problems. The strategic flow management analysis indicated a lengthy average visit of two hours. Additionally, the results of the internal analysis showed a large number of no-shows, and the strategic flow management analysis revealed a 48 percent "no-show" rate for dental and a 36 percent "no-show" rate for medical. The strategic flow management analysis showed poor productivity rates in dental and medical. The staff in dental was operating at a 31 percent productivity rate and in medical, the staff was operating at 33 percent productivity rate.

2. For Exhibit 20/5, provide a service delivery strategy recommendation for each item and finding for the dental area.

Summary of the Findings of the Strategic Flow Management Analysis and Strategy Recommendations: Dental

Item	Finding	***Service Delivery Strategy Recommendations***
Patient Privacy	No patient privacy because the waiting area, which includes patient sign-in and appointments, is open and available to all who walk by.	Create a separate area for sign-in and appointments by partitioning a small section for these functions.
Patient Scheduling	Appointments for both dental and dental assistant visits were being scheduled about 3 months out. The delays were attributed to missed "scheduled" appointments.	Open access scheduling for both dental and dental assistant visits.
Productivity	Levels of productivity for all 3 years are extremely low based on comparative data with other health departments.	Open access scheduling for visits and review of performance standards for staff.
Staffing	No staffing performance standards exist for Dental.	Set performance standards for each member of the dental staff.
Equipment	Adequate for workload, but will not be adequate for increased workload. Purchase additional equipment as workload increases.	Better utilization of existing equipment.
Facility Layout	Patients are moving through restricted clinical areas, which poses possible "contamination" and patient safety as well as infection control problems. Interference with clinical care delivery.	Relocate the Dental reception area to the main waiting area.
Information Technology	No electronic medical record. Medical records for each day are pulled the day before the patient visit. Current electronic database is not integrated with other e-systems. No electronic applications of mail functions such that all appointment reminders and mailings are done manually. Also, everything is recorded by hand multiple times.	Implement an electronic medical record system that can also be accessed by other state public health departments. Purchase an integrated software system that addresses multiple functions, such as billing, scheduling, inventory control, and accounting.

3. For Exhibit 20/6, provide a service delivery strategy recommendation for each item and finding for the medical area.

Summary of the Findings of the Strategic Flow Management Analysis and Strategy Recommendations: Medical

Item	Finding	***Service Delivery Strategy Recommendations***
Patient Privacy	Patients are called by name in the public waiting room. Clinical charts are held in the hallway that is accessible to both patients and all staff.	Hand held electronic devices similar to those used in other health care settings such as Emergency Departments may be used to electronically notify patients when their provider is ready for them. Electronic medical records would eliminate the chart problems.
Patient Scheduling	Length of time between patient contact and appointment date can be several months depending on specific service area within the medical division. High rate of no-shows and cancellations disrupt daily schedules. Although there is the high rate of no-shows and cancellations, nursing supervisors routinely discourage walk-in patients by not fitting walk-ins into cancellation and no-show scheduling slots. 50% of patients arrive early despite staff reports that late arriving patients created scheduling problems. Even those patients who arrive late are within a 5-minute range.	Open access scheduling promises to relieve the length of time between contact and appointment and also to remedy problems related to cancellations and no-shows. Additionally, electronic scheduling will support fulfillment of the benefits of open access scheduling. Education and training of staff relative to servicing their customers and the link between service delivery and organizational goals. Decision-making should be based on documented evidence rather than anecdotal. Electronic database would be supportive.
Productivity	Productivity levels are low primarily because of the time it takes patients to move through the care process at SCHD. Time spent in recording patient history for each visit negatively affects productivity. Staff typically spends on average about 15–30 minutes performing this function.	Establish performance standards for staff that reflect productivity measures. Revise the patient flow process to minimize patient movement and reduce patient time spent in non-clinical activities (i.e., moving from station to station). Initial patient history should be inputted into an electronic medical record. Patient history can be updated during subsequent visits.
Staffing	Physician coverage is inadequate. 25	Increase the physician salary and

	hours per week are scheduled, but in reality only 20 hours are provided. The mean salary for physician coverage is below average for the service area.	monitor the coverage hours so that the physician is paid for those hours of service provided.
Equipment	Equipment (clinical and business) is adequate. However, the location of some of the equipment is not conductive to efficient operations. For example, weight scales are found in hallways instead of in exam rooms.	Assure that equipment is located in the proper location to assure productivity.
Facility Layout	Layout is less than optimal. Patients typically move through four service areas during the course of a visit with the result of a 2-hour visit instead of 1-hour visit. Some rooms, such as the physician exam rooms, are not used when the physician is not present. Bottleneck areas have been created. For example, nurses congregate at the front desk waiting for their patients to arrive.	Move the staff to the patients instead of patients to staff. In this way, the patient remains in an exam room during the visit and staff move to them. This would free up two exam rooms and maximize use of staff time. Use all exam rooms. Use existing phone technology to call nurses when their patients arrive.
Information Technology	Need to upgrade to electronic medical records and use electronic databases to support their work.	Purchase an integrated software package and train all staff in use of software and link the software applications. Assure that staff understands the value of using the technology to improve productivity and enhance organizational performance.

4. The results of strategic thinking for SCHD should include formulation strategies, strategic alternatives, and strategy types selected. The students should create a table with these major categories.

Results of Strategic Thinking for SCHD

Formulation Strategies	Strategic Alternatives	Strategy Types Selected
Directional Strategies	Mission, Vision, Values, and Goals	N/A

Adaptive Strategies	• Expansion of Scope • Maintenance of Scope	• Market Penetration • Enhancement
Market Entry Strategies	Cooperation	Alliance
Competitive Strategies	Positioning	Differentiation

5. Given the current layout of SCHD and the findings in this case, plus no funds to do a remodeling of the facility, prepare a recommended new floor plan layout for the new administrator of SCHD.

Many different floor plans would be acceptable. A new flow plan by the authors is shown included as Exhibit 1 to this Note.

See attached floorplan – Exhibit 1 of this Note.

6. Based on the information in the textbook on point of service strategies, create a strategic thinking map for evaluating point-of-service and support strategies for SCHD.

See attached Exhibit 2 to this Note.

Exhibit 1

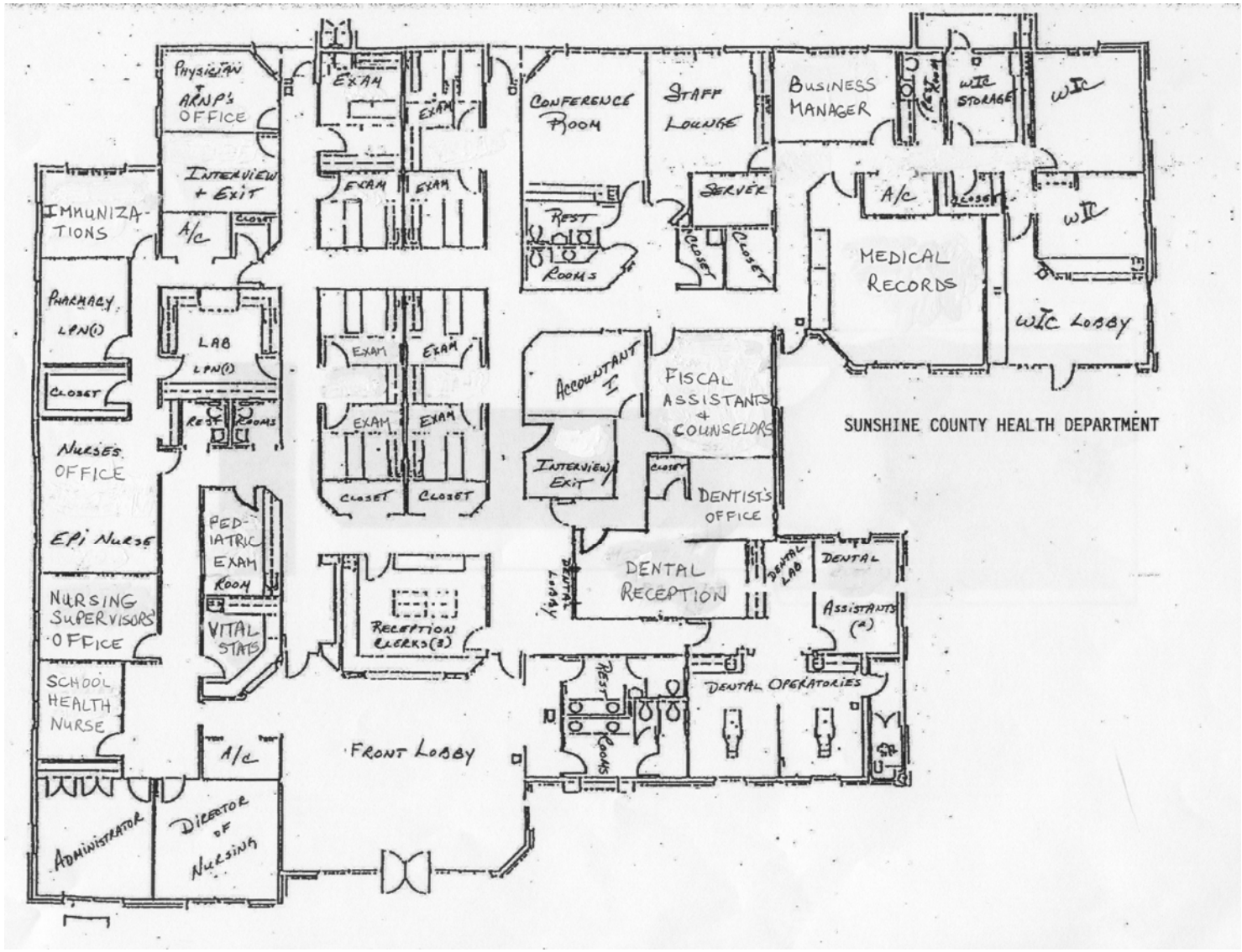

PHYSICIAN & ARNP's OFFICE
EXAM
EXAM
CONFERENCE ROOM
STAFF LOUNGE
BUSINESS MANAGER
WIC STORAGE
WIC
INTERVIEW + EXIT
EXAM
EXAM
SERVER
A/C
CLOSET
IMMUNIZATIONS
A/C
CLOSET
REST ROOMS
CLOSET
CLOSET
WIC
PHARMACY LPN(1)
LAB LPN(1)
EXAM
EXAM
MEDICAL RECORDS
WIC LOBBY
CLOSET
REST ROOMS
ACCOUNTANT I
FISCAL ASSISTANTS & COUNSELORS
SUNSHINE COUNTY HEALTH DEPARTMENT
NURSES OFFICE
EXAM
EXAM
INTERVIEW EXIT
CLOSET
DENTIST'S OFFICE
CLOSET
CLOSET
EPI NURSE
PEDIATRIC EXAM ROOM
DENTAL RECEPTION
DENTAL LAB
DENTAL
DENTAL LOBBY
NURSING SUPERVISORS OFFICE
VITAL STATS
RECEPTION CLERKS(3)
ASSISTANTS (4)
SCHOOL HEALTH NURSE
REST ROOMS
DENTAL OPERATORIES
A/C
FRONT LOBBY
ADMINISTRATOR
DIRECTOR OF NURSING

Exhibit 2 Strategic Thinking Map for Value Adding Support Strategies for Sunshine County Health Department					
	Characteristics/Attributes			**Evaluation**	**Support Strategy**
Value Adding Service Delivery Strategies	**Results of Internal Analysis**	**Results of Strategic Flow Management Analysis**	**Requirements of Selected Strategies**	**Comparison: Strategy Requirements-- Analyses Results**	**Guidance for Organizational Units (Basis for Unit Action Plan Development)**
Point-of-Service					
Service Delivery	Insufficient number of physicians/ARNPs	Staff operating at 31% productivity for dental	Expand Services:	Fairly good match	**Marketing -** Product Development:
	Poorly utilized space	Staff operating at 33% for medical	• Establish referral networks	Enhancement strategy requires improvement of service operations including e-technologies and productivity measures	• Increase patient referrals to the health department
	Service bottlenecks	48% no show rate for dental	Improve operational efficiency:		
	Large number of no-shows	36% no show rate for medical	• Adopt the electronic medical record		
	Scheduling problems	Length of average medical visit is about 2 hours	• Open access scheduling		
					Operations - Enhancement:
	"Can do: attitude of staff	Lengthy waiting time for walk-ins	• Relocate registration area for dental		• Initiate an electronic medicalrecord system.
	Highly qualified staff		• Staff training		• Implement an open access scheduling system
	Absence of updated technologies such as the electronic medical record.		• Monitor physician coverage		• Initiate a productivity measurement system
					Clinical – Enhancement:
					• Increase service delivery at a higher level of quality and caring.