13 CASE

Emanuel Medical Center: Crisis in the Health Care Industry

The Haley Eckman Story

On Friday, four-year-old Haley Eckman stayed home from school because of a slight fever. She complained that she was feeling very tired. That night, Haley's temperature increased to 104°F. At 3:15 A.M., Mr. and Mrs. Eckman took Haley to the emergency department (ED) of Emanuel Medical Center (EMC) in Turlock, California. They registered at the admissions desk and waited for someone to see them. After what seemed like forever to the Eckmans, a triage nurse came out to evaluate Haley. He asked several questions, but failed to take her temperature – a routine procedure in that situation. He then disappeared, leaving the Eckmans to wait yet again.

While they waited, Haley vomited. She said she felt very weak. The family asked if Haley could lie down in a bed while they waited to see a doctor. A staff member told them that there were no available

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This case study 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.

beds, and that they would have to wait. The Eckmans saw several empty beds across the hall from where they sat as the staff member said this.

At 4:35 A.M., the Eckmans were led to a room where a nurse took Haley's temperature and the physician on duty examined her. The physician assessed Haley's condition and ordered medicine that Haley could not keep down. Finally, the physician told the Eckmans that Haley had the stomach flu and that they should take her home to rest.

The following night, Haley's temperature hit 106°F. This time the family drove to Memorial Medical Center in Modesto, California, where she was diagnosed with a urinary tract infection and was treated with the appropriate antibiotics.

Mrs. Eckman was so upset about Haley's treatment at EMC that she contacted the California Department of Health Services and registered a complaint. She then contacted the local newspaper about the incident. The Department of Health Services came to EMC, conducted an investigation, and concluded that standard ED procedures were not followed and that the staff did not act in a considerate and respectful manner.

More Problems Than the ED

Mr. Robert Moen, EMC president and CEO, was experiencing a number of challenges in 2002. First, there had been significant negative attention for Emanuel Medical Center following the newspaper accounts and a state investigation of the Haley Eckman incident. The emergency department at EMC was experiencing greater pressure to deliver services in an increasingly difficult health care environment, particularly in light of federal EMTALA (Emergency Medical Treatment and Active Labor Act) legislation that required access to emergency medical care for all, regardless of ability to pay. Bernadette Khanania, EMC's ED Director, said, "I think when the EMTALA rules changed, it had an impact. The trend is sicker patients in the ED. It has to do with managed care, full practices, and older patients. It's not just our ED; every ED is seeing these changes."

The cost of operating the emergency department had risen precipitously and patient flows vastly exceeded the capacity for which the ED had been designed. Moen commented, "We don't get paid enough for the emergency department patients that we see. Not being paid adequately means that we can't build for the future."

An ED nurse agreed: "The patients are much sicker when they come in because they wait longer, so the pace is faster."

In addition, reimbursements for services from health maintenance organizations (HMOs) and government programs had been drastically reduced, at the same time that paperwork and other regulatory burdens had increased. EMC was beginning to experience labor shortages, particularly of nurses, that were driving up EMC's cost of operations. And, for-profit managed care facilities were making significant incursions into EMC's service area. According to Moen, "Kaiser Permanente has announced plans to build a facility in our area."

The net effect of all of these factors was increasing pressure on the profitability of EMC. EMC's operating margins had been negative for some time, contributing to increased pressures on cash flow. Moen said, "I am beginning to think that

the pressures placed on us by our stakeholders potentially threaten the hospital's survival. I don't know whether we should merge the hospital with a competing organization or one of the HMOs, try to sell the hospital, close the ED, close the hospital outright, or work harder to alter operations and turn it around."

US Health Care Industry

US national health expenditures totaled $1.553 trillion in 2002. This amount represented 14.9 percent of US gross domestic product (GDP) according to the US Centers for Medicare and Medicaid Services.[1] By way of contrast, US national health expenditures in 1980 were $245.8 billion and 8.8 percent of US GDP. Growth in national health expenditures began to outpace growth in US GDP in 1999 and this trend was forecasted to continue well into the twenty-first century.

Growth in spending on hospitals, physicians, and pharmaceuticals rose rapidly during this time period. National spending on hospital services rose from $378.5 billion in 1998 to $486.5 billion in 2002, an increase of 28.5 percent. Spending on physician and clinical services rose 32.2 percent, from $256.8 billion to $339.5 billion, during this same time period. The largest increase, however, was spending on pharmaceuticals. US consumers spent $162.4 billion on pharmaceuticals in 2002, an increase of 87.3 percent from 1996. From 1994 to 2002, annual US spending on pharmaceuticals almost tripled, according to the US Centers for Medicare and Medicaid Services.[2] Exhibit 13/1 contains key statistics of the US health care industry.

The precipitous rise in health care expenditures was accompanied by a rapid consolidation of health care facilities. The total number of hospitals in the United

Exhibit 13/1: US Health Care Industry Key Statistics: 1998 to 2002

	Year				
	1998	**1999**	**2000**	**2001**	**2002**
National Health Expenditures ($ billions)	1,150.3	1,222.6	1,309.4	1,420.7	1,553.0
Annual Percent Growth Rate in Expenditures	5.3	6.3	7.1	8.5	9.3
US GDP ($ billions)	8,782	9,274	9,825	10,082	10,446
Annual Percent Growth Rate in GDP	5.6	5.6	5.9	2.6	3.6
National Health Expenditures as a Percent of GDP	13.1	13.2	13.3	14.1	14.9
US Medicare Expenditures ($ billions)	204.0	206.2	217.5	239.2	259.1
US Medicaid Expenditures ($ billions)	93.2	100.9	109.8	122.5	137.0
US Hospital Facilities					
Number of Hospitals	5,015	4,956	4,915	4,908	4,927
Not-for-Profit Hospitals	3,026	3,012	3,003	2,998	3,025
State/Local Government Hospitals	1,218	1,197	1,163	1,156	1,136
For-Profit Hospitals	771	747	749	754	766

Source: Centers for Medicare and Medicaid Services; American Hospital Association.

States actually decreased from 1996 to 2002 as consolidation and closures occurred. In 1996, there were 5,134 community hospitals, but that number decreased to 4,927 by 2002. Fully 61 percent of US hospitals were operated as not-for-profit entities. In 2002, state and local governments operated 1,136 hospitals, 14.6 percent less than in 1996. Corporate, for-profit hospitals were actually the smallest group, numbering 766 hospitals in the US in 2000, according to the American Hospital Association.[3]

Regardless of the ownership status or size, all hospitals were subject to the same cumbersome governmental regulations. From the workplace safeguards of the Occupational Safety and Health Administration (OSHA) to the patient safety mandates of Title XXII of the Federal Health and Safety Code, regulation played a large role in health care. It was rumored in the industry that if a person were to gather together all of the documents that related to federal billing regulations for Medicare, it would fill a 40-ft tractor-trailer. At the federal level, the Office of the Inspector General (OIG) was mandated to oversee regulatory compliance in the health care industry.

EMTALA

A significant change in the regulatory environment occurred in 1986. The Emergency Medical Treatment and Active Labor Act (EMTALA) was made federal law that year. The legislation was passed after a gang member died in the parking lot of a hospital in plain view of emergency department staff. In passing this law, the federal government mandated access to emergency medical care for all people, regardless of their ability to pay, once they were present on the grounds of a hospital. It was designed to address emergency facilities' refusal to treat patients with serious conditions who were not able to pay for the services. Although the legislation was passed in 1986, it was not until the late 1990s that it began to be actively enforced. Investigations of EMTALA violations increased markedly at that time and fines up to $50,000 per incident were levied on both hospitals and physicians.[4]

With rapid growth in the number of underinsured and uninsured US citizens during the same period, the EMTALA legislation posed a significant challenge for hospitals and their emergency departments. Although it made perfect sense to care for those who were in critical condition before asking any financial questions, the EMTALA regulations had turned the most expensive department in a hospital into a free clinic for underinsured and uninsured patients that were largely in need of routine primary – not emergency – medical care. It was rapidly bankrupting many hospitals in the process.

The Role of Government

All of this regulation came with a direct cost to consumers, and consumers were increasingly concerned. "Health care ranks as the voters' top concern; recent spurts in costs have provoked more pressure – from employers and consumers – for changes than at any time since the failure of the Clinton national health

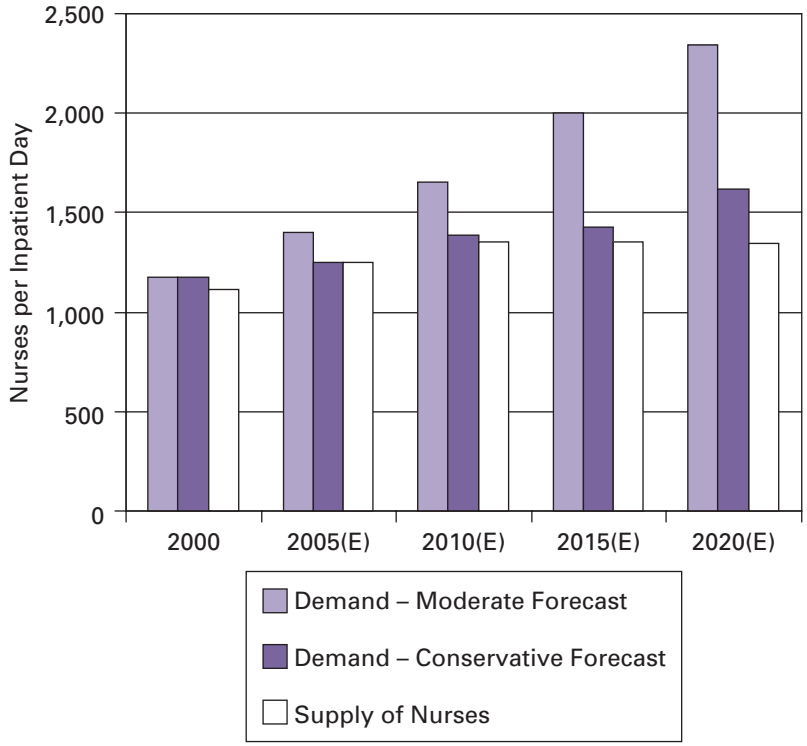
insurance initiative in 1994," according to J. Cummings in the *Wall Street Journal*.[5] The federal government, through the Balanced Budget Act of 1997, contributed to cost pressures in the industry by decreasing reimbursements for Medicare.

Staffing Shortages

Hospitals were dealing with chronic staff shortages. Demand for health care services was increasing rapidly at the same time that the labor pool for nurses, in particular, was leveling off. The increasing average age of active nurses was further exacerbating this problem.[6] (See Exhibit 13/2 for estimated imbalance between nurse supply and demand in the United States through 2020.)

Consequently, salaries paid to nurses were rising rapidly. Health care employers were attempting to increase the attractiveness of nursing jobs for qualified professionals. Employers had become increasingly willing to offer flextime and other nontraditional staffing arrangements to accommodate an increasingly stretched labor pool. These trends were expected to continue nationally for at least the next 20 years.

Exhibit 13/2: Registered Nurses, Estimated Supply and Demand from 2000 to 2020



Source: Health Care Advisory Board, 2000.

California Health Care Industry

In January 2001, the California Medical Association (CMA) produced its report, *California's Emergency Services: A System in Crisis*. The CMA president, Dr. Frank E. Staggers, commented on the report: "Because our emergency and trauma system is woefully underfunded, it may not be able to fully respond when we need it the most. This report shows we have much to do if we want to preserve an emergency medical system that's always available and truly protects the public." He continued, "California's health care system is struggling to adjust to serious underfunding of all services and provide care to more than 7 million uninsured Californians. The 'safety net' – that part of the system that serves as the first line of defense – has begun to unravel."[7]

Health care in California has been described as the "perfect storm." Declining reimbursements combined with increasingly onerous regulation and a shortage of nurses had led to negative operating margins for over half of California hospitals. From 1996 to 2000, 7 percent of the hospitals in California closed.[8] That left fewer emergency departments to care for the immediate needs of more patients and fewer beds to care for the chronically ill. These factors, combined with an aging population that increasingly demanded quality health care, produced a sharp increase in demand at exactly the time that the health care system had a reduced capacity to handle the patient load.

Of the hospital closures in California, the largest reduction had been in state and local government-owned facilities. Since 1996, 17 percent of state and county hospitals in California had closed. At the same time, the number of for-profit facilities decreased by 11 percent. The only sector resisting this trend was the not-for-profits. The not-for-profit sector closed less than 2 percent of its facilities during the 1996–2000 time period, placing intense pressure on the not-for-profit sector to handle the increasing demands of the health care system.[9]

On the expense side of the equation, California's hospitals confronted a challenging climate relative to other hospitals in the nation. They had higher patient costs than the national average (because of the impact of managed care on patient treatment patterns), higher wages for hospital employees, a significant nursing shortage, and the third-largest uninsured population in the nation.

Managed Care

Managed care exploded in California in the early 1990s because cost pressures on insurance premiums caused employers to look for ways to manage rising health care costs. Although HMO premiums held constant or decreased during this time period, the real pressure was on health care providers. Managed care shifted the risk of providing services from insurors to hospitals and physicians. These arrangements made the provider responsible for a person's health care, regardless of how much health care was consumed or how much it cost.

The new HMO payment arrangements created a need to manage the entire health care process, not just hospital care or medical care. This change gave rise to contractual and ownership interests in horizontal and vertical health care networks. "Vertical integration was seen by many as the solution to the problem that capitation posed for providers because it theoretically allowed a system to control the whole delivery system and therefore manage costs and utilization. During the past five years, empires have been built and have fallen," according to the Standard & Poor's industry survey.[10] Unfortunately, the tremendous costs associated with these networks forced some HMOs out of business and many health care networks and systems simply abandoned the experiment. Fortunately for the rest of the country, California tried it first.

Medi-Cal

Medi-Cal was the California state health insurance program for low-income families. In 2001, a total of 5.5 million persons per month in California were eligible for Medi-Cal (an increase of 8.2 percent over 2000). A total of $1.3 billion in nondental medical service fees were reimbursed by the State of California through Medi-Cal in 2001, representing a 14.0 percent increase over 2000, according to the California Department of Health Services.[11] During this time, California ranked 42nd out of 50 states in the level of per capita payments for health care.[12]

In 2001, the California Hospital Association litigated successfully to increase reimbursements, arguing that the state had failed to pay California hospitals at a reasonable rate. The settlement required the state to increase rates by 30 percent (an effective 2 percent increase per year) as well as paying a lump sum of $350 million to be split by all of the hospitals in the state.[13] Even with these increases, physicians and hospitals were reluctant to serve a high percentage of Medi-Cal patients because of the low reimbursements. According to an ED nurse at EMC, "The patients who are mostly on Medi-Cal . . . They come here to our ED at EMC." Dr. Robert Craig, an ED physician added, "Hospitals are having trouble dealing with the volume of patients that they treat."

Medicare

Beginning in 1983, Medicare (the federal program for the elderly) had reimbursed inpatient care at preestablished rates (the prospective payment system or PPS), but had paid for outpatient services at provider costs. In August 2000, however, a new policy was established to pay a fixed fee for all outpatient services as well. It decreased overall payments by 5 percent and greatly increased the paperwork associated with reimbursements. The new payment policy reduced out-of-pocket expenses to Medicare beneficiaries by lowering co-payments and standardized patient co-payments across facilities in the United States so that

patients would pay the same co-payment for services they received no matter where the care was provided. Prior to this change, Medicare patients paid 20 percent of their bills. Since charges varied widely across facilities throughout the country, a patient could end up paying ten times as much in out-of-pocket expenses at one hospital compared with another. For most hospitals in California, the mandated co-payment rate resulted in significantly lower reimbursements from Medicare.

HMOs

Health maintenance organizations routinely negotiated reduced fees with hospitals in exchange for sending their patients to the contracting hospital's facilities. In California, this arrangement had been around for over 20 years, but in the past 10 years the payment scheme had shifted to capitation. HMOs began to match Medicare reimbursements, routinely underfunding the expenses that hospitals incurred, making it unaffordable for the hospitals to provide patient treatment. By 2001, a large percentage of hospitals in California had exited from HMO capitation contracts; hospitals returned to adversarial negotiation, as had been done previously.

The result of this new, more adversarial relationship was to once again shift the rising cost of health care to HMOs and the employers that paid them. Hospitals, squeezed by underfunded and inadequate payments from government sponsored programs and faced with rising costs (such as EMTALA mandated emergency care), began extracting higher payments from commercial payors. Cost shifting drove commercial payments higher for the first time in several years. As the shifting continued, employers began to see dramatic increases in health care costs for their employees. Employers, as a consequence, then began to pass these costs on to their employees or to reduce the benefits provided. Employees, both directly or indirectly, began to pay more for their health care and became increasingly underinsured.

Physician Concerns

Physicians began seeing their incomes fall as managed care programs began to decrease reimbursements for medical services as well as hospital and other services. In the central valley of northern California, in particular, the high mix of Medi-Cal patients among all patients lowered the overall compensation of physicians, particularly those in specialty practices. In addition, managed care programs, and in particular Medi-Cal, had taken a great deal of autonomy away from physicians. Physicians complained that they were second-guessed by medical directors at HMOs as well as administrators at Medi-Cal. Physicians began being required to obtain administrative authorizations from managed care programs before proceeding with treatment and were increasingly denied these

authorizations if adequate documentation was not presented. Physicians found dealing with the process to be time consuming and increasingly frustrating. Service delivery and patient/customer satisfaction were seriously affected. In addition, a growing number of physicians simply refused to treat Medi-Cal patients because the cost of providing care to these patients exceeded what the State of California would reimburse.

Emanuel Medical Center

Emanuel Medical Center (EMC) of Turlock, California, was founded in 1917. Turlock was located approximately 100 miles east of San Francisco (see Exhibit 13/3 for a map). The hospital was established to serve the medical needs of all people in the local community, regardless of social, ethnic, or religious background. Founded by two pastors of the Swedish Mission Church, EMC operated on behalf of the Board of Benevolence of the Evangelical Covenant Church.

Mission, Vision, and Values

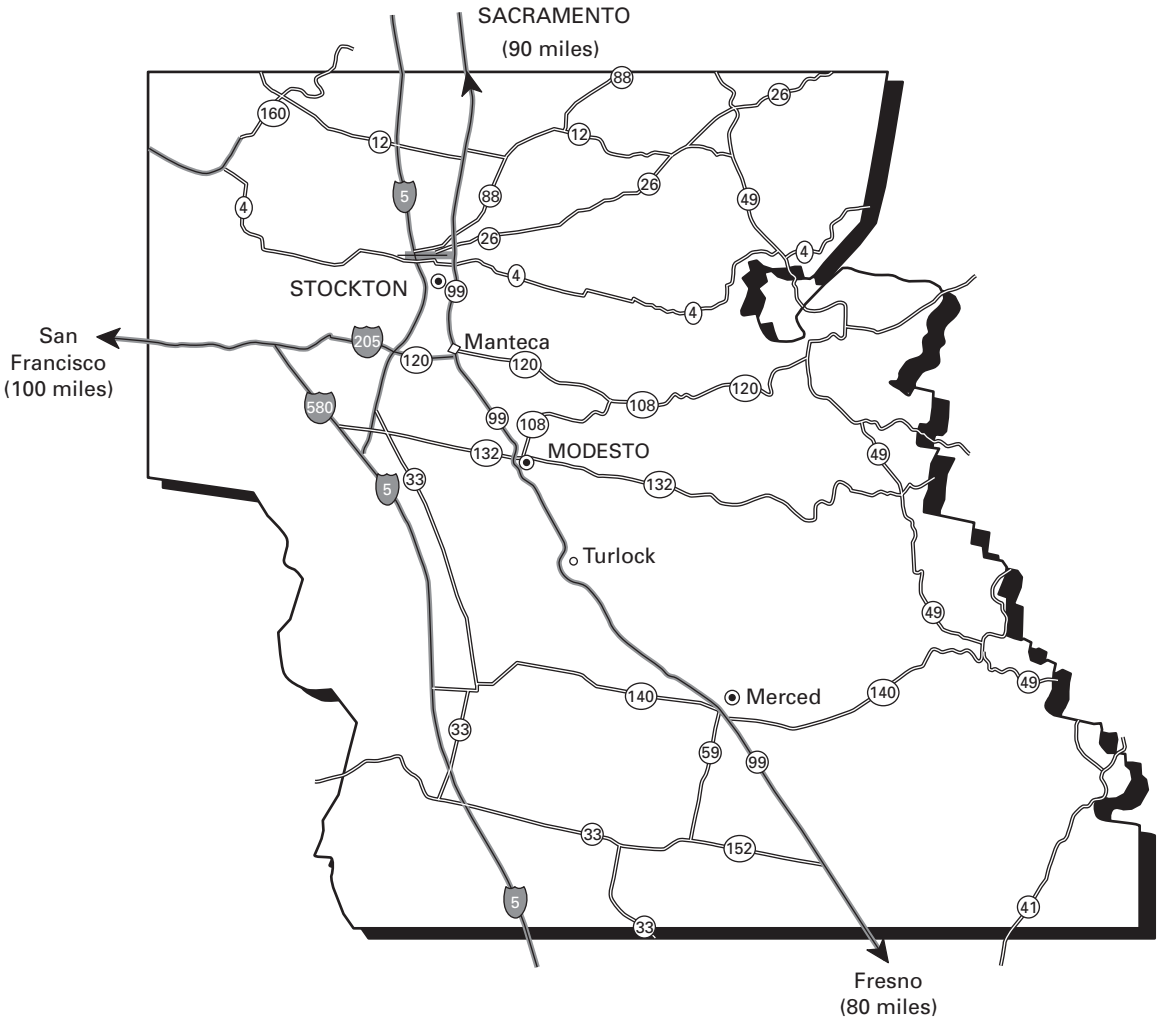
An early motto attributed to its founders described the mission of EMC as a "Christian service institution." In 2002, the mission of Emanuel Medical Center was to "create a healthier community." EMC's vision was to be "a caring community, caring for our community." The culture of EMC was built on a set of core values and beliefs that included: the affirmation of *life*, the pursuit of *justice* in the treatment of all individuals, *stewardship* of the lives entrusted to it, *integrity* in all of their actions, *collaboration* with individuals and the community to achieve their shared goals, and *excellence* in a commitment to exceed all expectations for their institution.

Emanuel Medical Center dedicated itself to implementing performance improvement measures for all critical hospital functions, providing excellent customer service, and continuously improving patient satisfaction. EMC identified three organizational goals around which it based its operating strategies and resource decisions. These three organizational goals were: caring for their customers and each other; providing clinical, operational, and service excellence; and growing revenue, facilities, and people.

Major Products and Divisions

Emanuel Medical Center was organized into three units: the acute-care 150-bed hospital, a 145-bed skilled-nursing facility, and a 49-bed assisted living facility. The central hospital facility handled acute inpatient services, including intensive care, monitored care, and general medical and surgical services. The site housed a comprehensive emergency department that never closed. Although there were 150 licensed beds, the occupancy rate of the hospital was typically little more than

Exhibit 13/3: Map of Turlock and Northern California



50 percent. Many of the rooms were semiprivate (two patients per room) and that tended to reduce patient satisfaction. However, one patient often received the exclusive use of a semiprivate room, if space allowed; that was typically the case with occupancy at 50 percent.

EMC's emergency department, on the other hand, was running well beyond full capacity. Built in the 1970s, the ED was designed for 16,000 visits per year. Over 45,000 patient visits were made to the ED during 2001. In addition, at any given time, over half of the patients admitted to the hospital for an extended stay came through the ED. This had increased the financial pressure on EMC,

because patients admitted through the ED were often the least able to pay or reimburse the hospital for services provided. Patients admitted to the hospital through a physician referral were much more likely to have comprehensive health insurance.

A full complement of outpatient services was available at the hospital site, including radiology, a clinical laboratory, and outpatient surgery. In addition, a separate diagnostic and rehabilitation center was housed on the hospital campus. This center enabled patients to have routine radiology exams, mammograms, and speech and occupational therapy on an outpatient basis.

Brandel Manor, the 145-bed skilled-nursing facility, rendered nursing and physical therapy services to patients needing around-the-clock care following surgery or a prolonged illness. Brandel Manor offered services for patients who could no longer live at home and required care because of the loss of mobility or some mental impairment. Brandel Manor maintained an average occupancy rate of better than 90 percent each year.

Finally, EMC owned and operated Cypress of Emanuel, a 49-bed assisted living facility. Cypress was an apartment-like setting for patients who had full mobility, but preferred the communal aspects of living. Residents received oversight for medication administration and group dining experiences to stay socially active. Occupancy was close to 100 percent. A constant waiting list existed for Cypress of Emanuel because it was an affordable alternative to other facilities in the area.

EMC's Service Area

EMC's primary service area consisted of the city of Turlock and eight smaller surrounding towns. Eighty percent of EMC's patients were residents of this primary service area; nearly 64 percent of patients were residents of Turlock. The secondary service area consisted of the additional 12 small towns that were geographically between 5 and 15 miles from EMC. Fourteen percent of EMC's patients were residents of the secondary service area. The remaining six percent of EMC's patients were from outside both these service areas.

Customer Demographics

EMC's customer base was growing, aging, and becoming more culturally diverse. EMC's primary service area had a population of approximately 200,000 in 2002, up from approximately 168,000 in 1998 (an increase of 19 percent). Baby boomers made up a fast growing proportion of the rapidly aging EMC patient population. In 1999, 40.1 percent of hospital patients at EMC were 65 years of age or older, 33.2 percent of patients were aged 15 to 44, and 10.2 percent were 14 years old or younger. EMC's service area had an estimated Hispanic population of approximately 65,000 (32.5 percent). By 1999, Hispanic patients were the fastest growing segment of ED admissions at EMC.

EMC Hospital Operations

Emanuel Medical Center was an organization with long-term employees working in a close-knit environment. They liked to project a caring, friendly feeling to those that visited their medical center. Many larger hospitals had multiple layers of management, high turnover rates, and little connection between employees. EMC had largely been able to maintain a small-town atmosphere at the hospital. They took complaints, such as the one made by the Eckmans, personally.

EMC had ranked in the 90th percentile for the past three Press Ganey Corporation surveys in total patient satisfaction. The initiative to improve these scores from beginning marks in the 70th percentile had involved the entire facility in an effort to deliver high-touch, friendly patient care.

One of the many benefits from EMC's intense focus on the patient was a reduction in costs. EMC had been benchmarked as a low-cost provider of services against statewide measures within its comparison group. Surveys through the Solutient Corporation against a national database showed that EMC was a benchmark hospital for salary cost per admission, supply cost per admission, and overall cost per admission.

Being a small-town hospital had some drawbacks, however. Larger hospitals tended to acquire new technology first. Although the hospital constantly updated equipment, EMC was sometimes perceived as low-tech because of a lack of some specialties, such as specialized cardiology services. Heart catheterization and surgery were not offered at EMC, but were available at hospitals in Modesto. This lack of specialization in some areas affected the bottom line of the hospital, because these high-tech specialties tended to be quite profitable.

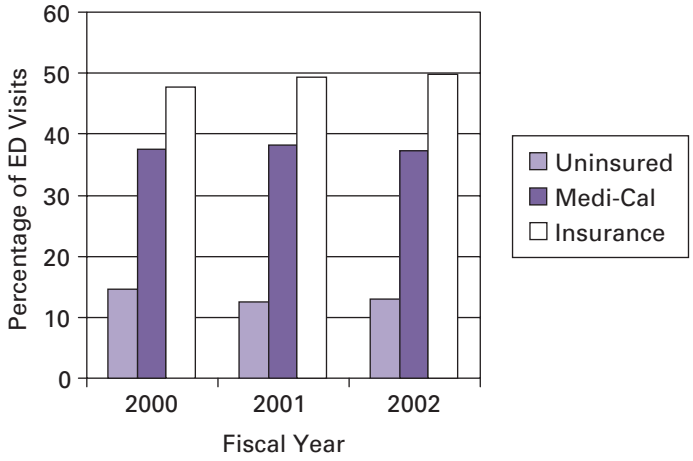
The emergency department was a growing area of concern. The department was built for patient volumes that existed over 25 years ago. An additional ED waiting room was built in the 1980s, but it had been outgrown. Many days the waiting room was full, the beds in the department were all full, and more patients and family members were becoming increasingly frustrated. Moen summed it up: "There are probably other things, but fundamental to the whole crisis is the lack of reimbursement. It squeezes us. We cannot finance out of operations the major expansions that we see we really need to do."

Top Management Team

The senior management team at EMC consisted of the president/chief executive officer and six vice presidents. These vice presidents led the divisions of finance, professional services, support services, patient care services, human resources, and development.

Robert Moen, president and CEO since 1986, had been at EMC for over 30 years. He had seen many changes as the facility grew through the late 1960s and early 1970s, but one of his biggest challenges was the emergency department. Moen believed that the problems experienced by patients such as Haley Eckman in the

Exhibit 13/4: Percentage of EMC Emergency Department Visits by Insurance Status, Fiscal Years 2000 to 2002



Source: EMC Company Documents.

ED were partly systemic. He said, "In much of the past 20 years, we were able to get by . . . In many cases it was because we were creative, careful, and selective in what we did. To ensure the future profitability of the hospital and our ability to provide services, we were able to build facilities when we needed to. However, we are in a place right now that, due to drastic cuts in reimbursements, we can barely stay up from an operational standpoint, let alone try to put money aside to build for the future."

Moen continued, "I'm concerned that over half of all emergency department patients admitted to EMC are either underinsured through programs like Medi-Cal or uninsured. From 2000 to 2002, our ED admissions increased 9.77 percent. During that time period, however, no more than 49 percent of ED admits had full health insurance coverage." Exhibit 13/4 shows a breakdown of payment types for EMC emergency department admissions.

Strategic Goals and Current Issues

EMC's top management team had set several strategic priorities for fiscal year 2003 (FY03) to FY06 to enhance EMC's position as a hospital of choice for both patients and the workforce:

- *Physician Development:* Recruit and retain the finest physicians, both general practice and specialists.
- *Product Mix:* Optimize product and service offerings to create growth and increase market share.

- *Facilities and Technology:* Create a "techno-edge" by wisely acquiring new technologies, as well as providing appropriate facilities for operations.
- *Contract Management:* Manage contracts with HMOs and governmental organizations for maximum reimbursement, keeping EMC a provider where financial conditions were favorable.
- *Quality Workforce:* Assure a quality workforce through offering competitive wages and benefits, as well as actively recruiting and retaining the best employees.

Moen had several operational issues on his mind. He said, "I'm concerned about shortages of critical care monitor beds and a lack of staff. Staffing is a statewide issue, but it affects all of us and causes management diversion from other operational concerns. On the physician backup side, we are struggling right now with recruiting and retaining a number of physician specialties and subspecialties. We don't always have adequate numbers of physicians with the right specializations locally to properly back up the demand in the emergency department."

He continued, "Another looming issue is the rising influence of managed care organizations. Since the 1990s, a number of health care facilities have been assimilated into managed care networks. For example, Memorial Hospital in Modesto was acquired by the Sutter network in 1996. In addition, Kaiser Permanente has made significant inroads." In 1998, Kaiser had 10,000 people insured in EMC's service area; at the end of 2001, that number had grown to 60,000. As of 2002, EMC no longer contracted to provide health care services to Kaiser's clients because Moen was unable to agree with Kaiser on reimbursement rates for services.

Moen constantly felt the pressure from government regulations and declining reimbursement rates. Changes in mandatory staffing levels for nurses, for example, had reduced the number of beds that EMC could offer for acute care at any given time. Moen stated, "I'm unclear about the future impact of other pending government legislation. Federal and state reimbursement rates are inadequate to meet hospital costs; yet state and federal budgets are strained, making any increases in reimbursement rates unlikely. I am certain that these outside forces will continue to exert tremendous downward pressure on EMC's bottom line."

Competitive Environment

Because of closures and consolidations, EMC was facing an increasingly hostile external environment. Four major health systems competed for business in EMC's service area: Sutter Health, Catholic Healthcare West, Tenet Healthcare Corporation, and Kaiser Permanente (see Exhibit 13/5).

Sutter Health

Sutter Medical Centers treated more inpatients than any other network in Northern California. Sutter Health was one of the nation's leading not-for-profit networks of community health care services, serving more than 20 Northern California

Exhibit 13/5: Competitors in EMC's Service Area

Company	Facility	Location	Number of Beds
Sutter Health	Memorial Medical Center	Modesto	300
Catholic Healthcare West	Mercy Hospital	Merced	115
	St. Joseph's Hospital	Stockton	294
Tenet Healthcare Corporation	Doctors Medical Center	Modesto	397
Kaiser Permanente	Doctors Hospital	Manteca	73
	Memorial Medical Center (under contract)	Modesto	300
	Dameron Hospital (under contract)	Stockton	192
Independent Hospital	Emanuel Medical Center	Turlock	150

Source: American Hospital Association, California Office of Statewide Health Planning and Development.

counties, from the Oregon border to the San Joaquin Valley, and from the Pacific coast to the Sierra foothills. In EMC's service area, Sutter owned Memorial Medical Center, a 300-bed full-service hospital. Memorial was located in Modesto, 20 miles north of Turlock. In 2001, Memorial Medical Center had 57,191 ED visits and had an average occupancy rate of 82.2 percent.[14] Memorial specialized in cardiac care, cancer services, and outpatient surgery and offered a family birthing center.

Catholic Healthcare West

Catholic Healthcare West, a not-for-profit health care provider, spanned a service area that encompassed parts of Arizona, Nevada, and most of California. It was the largest not-for-profit health care provider in California and the largest Catholic hospital system in the western part of the United States. Mercy Hospital of Merced, located in Merced, California, approximately 30 miles south of EMC, joined Catholic Healthcare West in 1996. Mercy was a 115-bed acute care hospital that specialized in maternity care, surgical services, critical care, emergency medicine, laboratory, radiology, and respiratory services and boasted an accredited sleep disorder lab. In 2001, Mercy had 45,561 ED visits and had an average occupancy rate of 42.1 percent.[15] In addition, Catholic Healthcare West owned St. Joseph's Hospital in Stockton, approximately 50 miles north of EMC. St. Joseph's had 294 beds and specialized in sports medicine, cancer, and cardiac care and offered an outpatient surgical center.

Tenet Healthcare Corporation

Tenet Healthcare Corporation, a nationwide for-profit provider of health care services, owned or operated 116 acute care hospitals and related businesses serving communities in 17 states. The company, headquartered in Santa Barbara, California, employed approximately 113,000 people nationwide. In EMC's service

area, Tenet operated Doctors Medical Center of Modesto and Doctors Hospital of Manteca.

Doctors Medical Center of Modesto began as a small 56-bed facility, but grew to become a full-care hospital, licensed for 397 beds. Located 20 miles north of Turlock, DMC Modesto held the contract to service the Yosemite National Forest, covering emergency evacuations and injury treatment. In 2001, Doctors had 52,487 ED visits and had an average occupancy rate of 60.7 percent.[16] It specialized in cancer treatment, neurosurgery, cardiac care, and pediatrics.

Doctors Hospital of Manteca was a much smaller facility. Located 35 miles north of Turlock, the Manteca facility had 73 beds with an average occupancy rate of 42.4 percent. In 2001, Doctors Hospital of Manteca had 14,145 ED visits, and specialized in occupational medicine.[17]

Kaiser Permanente

Kaiser, though a relative newcomer, was becoming a major player in local health care, with 60,000+ people insured in Stanislaus County. In EMC's secondary service area, Kaiser operated under contract through Dameron Hospital in Stockton, about 50 miles north of Turlock. Dameron had 192 beds, a 62.2 percent average occupancy rate, and 31,125 ED visits in 2001.[18]

Kaiser patients in Stanislaus County (EMC's primary service area) were treated at Memorial Hospital in Modesto, a Sutter affiliate. The partnership agreement between Kaiser and Memorial Hospital was to expire in February 2003. In November 2001, Kaiser announced plans to spend $1 billion in the Central Valley of California on medical facilities in or around Sacramento, Stockton, and Modesto. Thus, Kaiser's plans included a new hospital in EMC's service area. Kaiser had been aggressive in its marketing and promotion in Stanislaus County. Moen and the board anticipated that Kaiser would continue to push for greater coverage in EMC's primary service area.

Independent Hospitals

Of the four independent hospitals that were operational in EMC's primary service area in 1995, only EMC Medical Center remained open. The other independent hospitals, Bloss Memorial Hospital, Stanislaus Medical Center (the Stanislaus County-run facility), and Del Puerto Hospital, had all closed during the late 1990s. These closures mirrored the nationwide trend of hospital closures that occurred during the same time period.

Financial Status of EMC

With the dramatic growth in managed care in the late 1990s, EMC was under pressure to accept capitation or risk having no patients. Under the capitation payment

system, an HMO would pay a set amount per member per month (PMPM) to EMC to cover patient care costs for their covered members. PMPM was actually a prepayment, because fees were paid to EMC each month for each HMO member enrolled in its program, rather than paid out to EMC after services were rendered. Capitation reduced accounts receivable for EMC and improved EMC's cash flow on the front end. On the back end, however, the HMO payment rates and the relative risk that EMC faced were not aligned. Fully allocated costs for patient treatments regularly exceeded HMO payments to EMC and EMC began to experience significant losses from HMO-covered patient care.

The financial trends for EMC closely matched the HMO capitation experiment experienced by many hospitals in California. Although EMC saw the move into capitation in 1997 as a defensive strategy to retain HMO patients, the effect on EMC's bottom line became increasingly negative. As the contracts began to expire, EMC exited the HMO-sponsored capitation arrangements, restoring the hospital to marginal profitability.

EMC Revenues

EMC posted total income of $4.7 million in 2001, which was a net margin of 6.3 percent. During the same year, however, EMC lost $4.1 million on operations – a direct result of the rising costs of employee salaries and wages, as well as the growing losses from HMO capitation programs. Over the five-year period of capitation for EMC, all but the first year resulted in operating losses. Exhibits 13/6 and 13/7 present income statements and balance sheets for EMC from 1997 to 2002.

EMC's primary source of revenue was from operations, related to caring for patients, either inpatient (with an overnight stay) or outpatient. The more common types of outpatient care were same-day surgery, emergency department visits, and routine radiology procedures.

Over the past five years, EMC had developed significant revenues from nonoperating related sources. The primary source was income on investments that were made in the mid-1990s. During that time, the board of directors had adopted a capital structure that favored liquidity on EMC's balance sheet. By borrowing funds for expansion and investing unspent funds allocated for capital expenditures, EMC increased its capital reserves from $4 million to $23 million within three years. With strong returns from the stock market in the late 1990s, this reserve ballooned to over $50 million by the end of the decade. In the early years of the twenty-first century, this base provided a source of income that was sorely needed to shore up operating losses.

The second significant nonoperating source of income was fund raising. EMC was a not-for-profit charity and donors were given a tax advantage for their contributions. Over the history of EMC, the community had supported facility expansions and the ongoing activities of the development office. In 2001, EMC implemented an aggressive program to involve the community in building for the future. With a matching grant from the Mary Stuart Rogers Foundation, the

Exhibit 13/6: Emanuel Medical Center Income Statements, Fiscal Years 1997 to 2002 (in $ thousands)

	1997	1998	1999	2000	2001	2002
Net Patient Revenue	53,787	46,654	46,329	46,700	47,457	65,653
Other Revenue	720	821	939	1,084	1,022	1,192
Premium Revenue	1,265	7,115	7,198	8,187	7,666	1,715
Total Operating Revenue	**55,772**	**54,590**	**54,466**	**55,971**	**56,145**	**68,560**
Operating Expenses:						
Salaries and Wages	21,516	22,336	22,339	23,640	25,274	27,506
Employee Benefits	7,405	8,486	8,336	7,883	7,887	9,073
Professional Fees	2,749	2,590	1,783	2,271	2,368	4,643
Supplies	8,879	8,981	8,487	8,750	9,093	10,081
Purchased Services	3,603	2,981	2,749	2,897	3,195	3,774
Depreciation	3,563	3,627	3,774	3,768	3,623	3,533
Utilities	681	727	668	689	667	677
Insurance	826	920	591	405	393	527
Interest Expense	1,552	1,777	1,765	1,584	1,303	475
Bad Debt	1,389	1,978	2,627	2,938	4,357	6,155
Other	1,424	1,381	1,682	1,877	2,124	2,248
Total Expenses	**53,587**	**55,784**	**54,801**	**56,702**	**60,284**	**68,692**
Operating Income	**2,185**	**(1,194)**	**(335)**	**(731)**	**(4,139)**	**(132)**
Nonoperating Revenue:						
Interest and Dividend Income	968	1,217	1,284	1,465	2,620	2,084
Realized Gains (Losses) on Investments	1,005	2,733	3,578	7,885	5,707	(2,160)
Contributions	390	299	268	415	489	688
Total Nonoperating Revenue	**2,363**	**4,249**	**5,130**	**9,765**	**8,816**	**612**
Net Income	**4,548**	**3,055**	**4,795**	**9,034**	**4,677**	**480**
Unrealized Gains on Investments	1,792	(1,055)	2,394	2,848	(8,357)	(2,676)
Increase in Net Assets	6,340	2,000	7,189	11,882	(3,680)	(2,196)
Acute and ICU Patient Days (Actual)	26,048	25,342	23,895	25,330	25,051	27,006
ED Visits (Actual)	36,214	34,363	32,071	37,485	38,931	41,145

Source: California Office of Statewide Health Planning and Development.

community took part in a fund drive to expand the birthing center at EMC. During a five-week kick-off campaign, volunteers and employees raised over $1.4 million toward the $4 million project.

EMC Expenses

Expenses over the past three years had grown at a rate of 7.7 percent per year, with salaries and wages combined with benefits accounting for 4.1 percent. In addition, during 2002, EMC had to raise salaries for beginning nurses by as much

Exhibit 13/7: Emanuel Medical Center Balance Sheets, Fiscal Years 1997 to 2002 (in $ thousands)

	1997	1998	1999	2000	2001	2002
Current Assets						
Cash and Cash Equivalents	2,108	1,572	2,076	4,315	650	484
Trustee Held Funds	505	766	685	599	574	524
Accounts Receivable	7,693	8,967	8,722	7,708	9,650	10,987
Other Receivables	589	877	1,867	1,434	1,423	2,806
Inventory	925	952	977	1,054	1,073	1,043
Prepaid Expenses	288	22	44	15	246	365
Total	12,108	13,156	14,371	15,125	13,616	16,209
Investments						
Board Designated Investments	30,944	33,956	41,803	54,781	52,689	47,589
Trustee Held Funds	2,223	2,122	2,135	2,033	2,300	2,228
Total	33,167	36,078	43,938	56,814	54,989	49,817
Property and Equipment						
Land	1,509	1,509	1,509	1,509	1,509	1,509
Buildings and Improvements	39,811	39,932	40,935	41,206	43,152	44,099
Equipment	19,610	21,194	23,070	23,942	25,593	27,130
Construction in Progress	1,369	897	753	1,551	596	833
Property and Equipment (at cost)	62,299	63,532	66,267	68,208	70,850	73,571
Less Accumulated Depreciation	26,262	29,814	33,524	36,956	40,264	43,744
Property and Equipment, Net	36,037	33,718	32,743	31,252	30,586	29,827
Other Assets	658	603	902	1,784	1,316	1,165
Total Assets	81,970	83,555	91,954	104,975	100,507	97,018
Current Liabilities						
Accounts Payable	2,032	1,194	1,281	1,238	1,929	1,617
Payroll and Related Liabilities	2,055	2,314	2,440	2,692	3,088	2,171
Interest Payable	435	446	428	430	423	415
Other Current Liabilities	936	1,726	2,856	2,672	2,268	2,056
Current Portion of Long-Term Debt	627	685	804	964	630	615
IBNR Liability	545	450	1,085	1,273	1,582	288
Estimated Third-Party Settlements	1,537	1,515	1,373	3,047	2,184	2,272
Total Current Liabilities	8,167	8,330	10,267	12,316	12,104	9,434
Long-Term Debt	27,216	26,638	25,911	25,022	24,426	24,114
Total Liabilities	35,383	34,968	36,178	37,338	36,530	33,548
Total Net Assets	46,587	48,587	55,776	67,657	63,977	63,470
Total Liabilities and Net Assets	81,970	83,555	91,954	104,975	100,507	97,018

Source: California Office of Statewide Health Planning and Development.

as 27 percent to be competitive. The nursing shortage in California had increased the use of temporary nurses – that added significantly to labor costs.

EMC entered capitation in 1997 with a relatively low number of patients as HMO members. More important to EMC than the absolute dollars paid out for treatment of HMO patients under capitation payments was the percentage of this premium revenue that was given to other health care providers for services rendered. In 1997, 34 percent of HMO premium revenue received by EMC was paid out to other providers for health care services (such as cardiac surgery) that EMC was not equipped to provide for its members. In 2001, 54 percent of the HMO revenue EMC received went to other health care providers. This substantially increased EMC's losses on HMO capitation programs and contributed to EMC's eventual exit from this payment mechanism in 2002.

By 1998, however, EMC had 17,000 patients per year under this arrangement. This number of HMO-contracted patients remained fairly constant through the next four years. Capitation expenses had grown during the five-year period from $655,000 in 1997 to $8.9 million in 2001.

EMC management observed a significant increase in uncollectable debts payable to EMC after the county medical facility in Modesto closed in 1997.

Bottom Line

The EMC board of directors' decision to invest assets in stocks and bonds in the mid-1990s had a dramatic impact on EMC's financial health. Moen concluded, "If the board had not made these investments beginning in 1993, the financial viability of EMC would be in jeopardy."

Mr. Bruce Metcalf, chairman of EMC's board of directors, stated, "Given the size of our reserves, we are at least hopeful that we can weather the ups and downs of the current market environment as well as continue to plan for the future."

The Future of Emanuel Medical Center

Moen stated, "I have seen a number of significant changes in the health care industry, but nothing like I'm seeing now. I am concerned about EMC's ability to survive and prosper in this radically altered health care environment."

"Yes, we're at risk if we continue to get influxes of patients who are not financially solvent. I mean, at some point somebody could decide this is costing us more money than it's worth. That's why EDs close," Dr. Robert Craig, an ED physician, agreed.

Moen continued, "We have a number of challenges, including a new landscape of state and federal regulation, unfunded mandates from government programs, and a growing financial misalignment between health care providers, facilities, and patients. These issues are most serious in our emergency department. Open access to the emergency department has become the fail-safe mechanism for what I regard as an increasingly broken health care system." He acknowledged, "Just about

everybody is unhappy with the emergency department. Haley Eckman's treatment seems to personify the current dilemma of our ED. Service standards are declining, morale is slipping, and staffing is challenging as we try to handle patients arriving at our ED for care." Moen concluded, "Emergency departments across the state are becoming inundated with people seeking primary medical care because they have little or no access to a physician. Unfortunately, this is the most expensive form of health care delivery, and it is increasingly impacting the bottom line at EMC. Although we are a not-for-profit, the situation is grave."

Half jokingly, Moen suggested to an influential EMC donor, "Maybe we should consider closing the hospital."

"Closing the hospital is not an option," the individual growled back.

Moen replied, "Support for the hospital is very strong in the community. Closing the ED doesn't really seem an option either. Half of EMC's hospital admissions come through the ED. Medical inpatient care and general surgery are the hospital's most profitable areas and they are closely aligned with ED admits."

Moen worried: "We are the last independent hospital in this area. All of the other independent hospitals in our primary service area have closed. How long can we resist the incursion of managed for-profit health care facilities? Kaiser Permanente, in particular, has achieved significant growth in this region during the past four years." He continued, "Depending on the course of future events, EMC could come under significant pressure to either contract with or be acquired by Kaiser or another major for-profit provider. Kaiser is poised to make significant inroads into our service area in the next 18 months. The outcome of Kaiser's actions could change this market dramatically.

"We are addressing operational issues affecting EMC," Moen went on. "Physicians are in short supply, as well as other health care professionals. Nurses, in particular, are really difficult to retain. When we have nursing shortages, we can hire temporary nurses, but it is very expensive. And, it's difficult to integrate temporary nurses into the EMC community. The staffing situation has become critical enough sometimes to affect emergency department operations."

Moen continued, "We've looked at the problem of the medically underinsured and uninsured that the ED is experiencing. I've thought about becoming a federally funded clinic to cope with these pressures. And we – the medical staff, the board, and me – have discussed the need to expand the ED facility. Either option, however, requires capital that is in short supply. We need to improve the overall patient mix for the hospital. We need to attract and retain patients with a greater ability to pay full fees, including elective surgeries.

"Margins at EMC are under pressure. I'm thankful for the board's investments in the late 1990s: that cushioned the blow, but for how long? The rising salaries have caused operating margins to remain negative. Our withdrawal from HMO capitation programs helped increase revenues but the increases are not enough to offset the underfunded government programs. We have to restore the hospital to profitability," he concluded. Moen paused and thought for a moment about little Haley Eckman, scared and sick in the emergency department of Emanuel Medical Center. "We have to do better."

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