CASE 11

Riverview Regional Medical Center: An HMA Facility

Matt Hayes, executive director of Riverview Regional Medical Center (RRMC), reviewed the performance indicators for the 2004 fiscal year (see Exhibit 11/1). As he studied the numbers, he mentally reviewed key events and decisions over the past year that had contributed to some of the more dramatic changes in the annual profile. And, he considered what new challenges might confront him now that his chief competitor, Gadsden Regional Medical Center (GRMC), had a new executive director who would almost certainly attempt to alter the status quo in the local hospital market.

Health Care Providers

In 1993, Merrill Lynch predicted: "In the larger urban areas, HMOs would . . . continue to be the coordinator and provider of health care services. However, in nonurban markets, the hospital would be the

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This case was written by Woodrow D. Richardson, Ball State University, and Donna J. Slovensky, The University of Alabama at Birmingham. It is intended to be used as a basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission of Woody Richardson and Donna Slovensky.

Exhibit 11/1: RRMC Key Volume Indicators, FY 2002–FY 2004

Indicator	FY 2002	FY 2003	FY 2004
Open Heart	324	330	199
Cardiac Catheterization	7,661	9,704	6,548
Coronary Stents	942	1,420	795
Inpatient Endoscopy	1,300	1,360	1,227
Outpatient Endoscopy	2,354	2,263	2,283
Inpatient Surgery	2,922	2,873	2,068
Outpatient Surgery	3,047	2,806	3,301
Inpatient CT Scans	4,685	4,309	4,099
Outpatient CT Scans	6,087	5,753	6,440
Inpatient MRI	826	805	1,165
Outpatient MRI	2,915	2,534	2,434
Outpatient Visits	61,865	55,340	51,736
Births	887	433	0
Inpatient Admissions	10,530	9,710	8,482
Inpatient Admissions Via ER	5,527	5,253	5,011
ER Visits	25,452	24,764	24,347
Medicare Discharges	5,736	5,646	5,308
Medicare ALOS	6.28	6.33	6.2
Medicare Case Mix Index	1.53	1.62	1.46

cornerstone and coordinator of health care services for the health alliance purchasing cooperatives which would be formed under managed competition proposals."

At the individual provider level, some experts insisted that the financial power base was moving away from solo practices and independent small groups toward integrated, cost-competitive, comprehensive systems that produced a single patient bill including the charges of the physicians, the hospital, and the outpatient services. Integrated systems required a corporate structure to facilitate sharing of capitated risk. Throughout the 1990s, mergers and other types of strategic alliances between physicians' practices, and between hospitals and physicians' practices, had increased in an effort to reduce costs and become price competitive. Small group practices often lacked the administrative and management expertise as well as the material resources necessary to improve efficiency. They were advised to look for such capabilities when they sought potential partners.

Many physicians remained skeptical of mergers, partnerships, or alliances offering any competitive advantage. That skepticism occurred most often in areas where managed care was absent or limited. Exhibit 11/2 shows the penetration of managed care in selected southern states.

Rural and Nonurban Health Care Market

Forty-nine percent of the United States population resided in counties classified as rural or nonurban. Nonurban areas had 44 percent fewer doctors per 100,000 residents than urban-designated areas. Since 1981, more than 200 nonurban hospitals

Exhibit 11/2: HMO Penetration in Selected States

State	Percentage
Alabama	3.8
Florida	26.0
Georgia	13.4
Texas	12.8
California (reference point)	48.5

Source: InterStudy Staff, *The InterStudy Competitive Edge, Part II: Managed Care Industry Report* (St. Paul, MN: InterStudy, 2003). Data abstracted from: http://www.medicarehmo.com/mcmnu.htm, accessed September 20, 2004.

had closed. Many hospitals continued to underperform and were failing because of ineffective operations.[1]

Rural and nonurban hospitals had become hot acquisition targets for investor-owned health care companies. For the nation's 2,400 rural hospitals – acute care facilities located outside of a metropolitan statistical area – the status quo was not acceptable.[2] Hospitals that chose to remain independent faced an uncertain environment where 60 percent to 75 percent of revenues were attributed to Medicare. Threatened by the prospect of declining federal reimbursement coupled with the lack of resources to invest in costly information systems, many local governments that owned rural and nonurban hospitals were looking for a way out.[3]

When it came to the inverted "field of dreams" logic used by small hospitals in the past, no other firm had been as successful as Health Management Associates, Inc., according to chairman of the board, William Schoen. "Whereas other hospitals [think], 'We are here and you will come,' we're in the customer service business," Schoen said.

Health Management Associates (HMA)

HMA was ahead of the growing throng of firms targeting rural and nonurban markets where the presence of managed care was less intense and where physicians perceived good opportunities. HMA generally employed a decentralized approach; operations were left to the executive directors of each hospital. Only financial controls were centralized. Founded in 1977, HMA acquired, improved, and operated hospitals in high-growth, nonurban areas in the Southeast and Southwest, where the growing population created a need for comprehensive health care services. HMA sought to turn around nonurban hospitals in growing communities with populations of 30,000 to 400,000 with a clear demographic need. The company looked for states with certificate of need (CON) regulations and an established physician base. Using a proven acquisition and management strategy, HMA consistently turned hospitals into efficient, state-of-the-art medical facilities that provided high-quality care. From 1991 to 2004, HMA acquired 38 hospitals, bringing its total count to 53 hospitals in 16 states. William Schoen, HMA chairman of the board, and Joseph Vumbacco, president and CEO, saw no

shortage of acquisition prospects. Cost pressures coupled with inadequate coping resources would continue to affect many community hospitals adversely.

In 2003, HMA had a net income of $283.4 million on net patient service revenues of $2.56 billion. The company showed consistent growth from 1999, when net income was $150 million and revenues were $1.36 billion. Admissions rose 8.9 percent to more than 235,000 in 2003. Patient days and emergency room visits grew in 2003 to 1.1 million and to 914,000 respectively. Revenues of hospitals operated for at least 12 months grew by 7.9 percent over the year ended in 2003. Admissions for these hospitals were up 2.9 percent, and ER visits were up by 5.1 percent. Correspondingly, the hospitals' occupancy levels grew to 47.7 percent in 2003 versus 47.1 percent in 2002.

HMA had a small corporate overhead. The company employed about 100 people in its Naples, Florida, corporate office. Exhibit 11/3 provides information on the corporate officers' backgrounds.

Exhibit 11/3: HMA Board of Directors' Background Information

Name	Position	Year Elected
William J. Schoen	Chairman of the Board, Health Management Associates, Inc.	1983
Kent P. Dauten	President, Keystone Capital, Inc.	1981
Robert A. Knox	Senior Managing Director, Cornerstone Equity Investors, LLC	1985
Charles R. Lees	Director Emeritus, KPMG Peat Marwick LLP (retired)	1988
William E. Mayberry, MD	President and Chairman of the Board of Governors (retired), Mayo Clinic	1991
Randolph W. Westerfield, PhD	Dean, Marshall School of Business, University of Southern California	1982
Joseph V. Vumbacco	President and Chief Executive Officer, Health Management Associates, Inc.	1985
Donald E. Kiernan	Senior Executive Vice President and Chief Financial Officer (retired), SBC Communications, Inc.	1982
William C. Steere, Jr.	Chairman Emeritus of Pfizer, Inc.	1983

William J. Schoen served as Chairman of the Board since April 1986. He was first elected a director in February 1983, became President and Chief Operating Officer in December 1983, Co-Chief Executive Officer in December 1985, and Chief Executive Officer in April 1986. He served as President until April 1997 and Chief Executive Officer until January 2001. From 1982 to 1987, Mr. Schoen was Chairman of Commerce National Bank, Naples, Florida, and from 1973 to 1981 he was President, Chief Operating Officer, and Chief Executive Officer of The F&M Schaefer Corporation, a consumer products company. From 1971 to 1973, Mr. Schoen was President of the Pierce Glass subsidiary of Indian Head, Inc., a diversified company.

Kent P. Dauten served as a Director from March 1981 through May 1983, and from June 1985 through September 1988. He was again elected a Director in November 1988. Since February 1994, Mr. Dauten has been President of Keystone Capital, Inc., a private investment advisory firm he founded.

Exhibit 11/3: (*cont'd*)

Mr. Dauten was formerly a Senior Vice President of Madison Dearborn Partners, Inc., a private equity investment firm, and of First Chicago Investment Corporation and First Capital Corporation of Chicago, the venture capital subsidiaries of First Chicago Corporation, where he had been employed in various investment management positions since 1979.

Robert A. Knox became Senior Managing Director of Cornerstone Equity Investors, LLC, an investment advisory firm, in December 1996. From 1994 until December 1996, he was Chairman and Chief Executive Officer, and from 1984 to 1994 he was President, of Prudential Equity Investors, Inc., an investment capital firm. Prior to that, Mr. Knox was an investment executive of The Prudential Insurance Company of America. He served on HMA's Board of Directors since 1985.

Charles R. Lees was elected a Director in February 1989. Mr. Lees has been in the private practice of law, concentrating in tax matters, since May 1985. He was a Project Director for the Governor's Tax Reform Advisory Commission in California from August 1984 to September 1985. From 1979 to 1983 he was a visiting professor at the School of Accounting, University of Southern California. For more than 20 years prior to his retirement in 1979, Mr. Lees was a partner in the accounting firm of Peat, Marwick, Mitchell & Co., specializing in tax matters.

William E. Mayberry, MD was the retired President and Chief Executive Officer of the Mayo Foundation and the retired Chairman of the Board of Governors of the Mayo Clinic, Rochester, Minnesota, where he had been employed in various capacities from 1956 until his retirement in 1992.

Randolph W. Westerfield, PhD served as Dean, the Marshall School of Business, University of Southern California, Los Angeles, California, since 1993. For the previous 20 years he was a member of the finance faculty at the Wharton School of Business at the University of Pennsylvania. In addition, Dr. Westerfield served on the Board of Directors of William Lyon Homes and Nicolas Applegate Growth Equity Fund.

Joseph V. Vumbacco became Chief Executive Officer of the company in January 2001. Prior to that, and since April 1997, he was the Company's President, as well as serving as Chief Administrative Officer and Chief Operating Officer. He joined the company as an Executive Vice President in January 1996 after 14 years with The Turner Corporation (construction and real estate), most recently as an Executive Vice President. Prior to joining Turner, he served as the Senior Vice President and General Counsel for The F&M Schaefer Corporation, and previously was an attorney with the Manhattan law firm of Mudge, Rose, Guthrie & Alexander.

Donald E. Kiernan was the retired Senior Executive Vice President and Chief Financial Officer of SBC Communications Inc. (telecommunications), a position he held from October 1993 to August 2001. Prior to that, and since 1990, he served as Vice President of Finance for SBC Communications Inc. Mr. Kiernan was a Certified Public Accountant and former partner with Arthur Young & Company. Mr. Kiernan served on the Boards of Directors of Horace Mann Educators Corporation, LaBranche & Co Inc., Seagate Technology, and Viad Corp.

William C. Steere served as a director of the company since May 2003. He was the Chairman Emeritus of Pfizer Inc. since July 2001, a Director since 1987, and was Chairman of the Board from 1992 to April 2001 and Chief Executive Officer from February 1991 to December 2000. Mr. Steere served on the Board of Directors of Dow Jones & Company, Inc., MetLife, Inc., the New York University Medical Center, and The New York Botanical Garden, as well as on the Board of Overseers of Memorial Sloan-Kettering Cancer Center.

Source: Company documents.

Corporate Philosophy and Mission

HMA's Statement of Corporate Philosophy defined its goals and principles as a health care provider, employer, and publicly traded company. A cornerstone of HMA's philosophy was the conviction that all employees, at every hospital and at the corporate office, shared a common objective of providing quality service to the many different customers of its business. HMA's guiding objectives were as follows:

- To provide the highest quality of service to our patients, physicians, and the communities we serve.
- To provide employees with a satisfying and rewarding work environment.
- To provide an attractive return on investment to those who are investors in the Company.
- To function as a good corporate citizen in the communities we serve.
- To manage HMA in a manner that maintains uniform strength and identity while allowing individual hospitals the degree of independence necessary to maximize innovation and efficiency and meet the individual needs of the communities they serve.

Corporate Strategy

When originally established in 1977, HMA intended to compete as a national firm owning, leasing, and managing hospitals throughout the United States. In 1983, HMA redirected its focus to a niche of hospitals located in nonurban communities in the Southeast and Southwest with 30,000 to 400,000 in population. The officers believed the very nature and size of the facilities (generally 200 beds or fewer) located in nonurban communities precluded the individual, non-system-affiliated hospitals from attracting experienced and professional medical practitioners in each area of specialty. On the other hand, they believed that through system affiliation with HMA and its concomitant infusion of capital and management expertise, the same financially troubled hospitals could become profitable.

To penetrate the niche markets, HMA executives believed it was necessary to provide management expertise and medical technology in specific areas to reduce costs, attract physicians, and increase the scope and quality of service – all within a profitable framework that would halt the out-migration of patients to larger metropolitan areas for as many surgical procedures as possible. They believed that achieving these objectives allowed the communities HMA served to forge the viable and effective health care delivery facilities that they desperately needed.

Facilities

In August 2004, HMA operated 53 facilities (see Exhibit 11/4) consisting of just under 7,000 beds. HMA hospitals offered a broad range of inpatient and outpatient health services with an emphasis on primary care. Inpatient programs at all facilities included a wide variety of medical and surgical services, diagnostic

Exhibit 11/4: HMA Facilities in 2004

Location	Hospital	Facility Type	Licensed Beds
Alabama			
Anniston	Stringfellow Memorial Hospital	General Medical/Surgical	125
Gadsden	Riverview Regional Medical Center	General Medical/Surgical	281
Arkansas			
Little Rock	Southwest Regional Medical Center	General Medical/Surgical	125
Van Buren	Crawford Memorial	General Medical/Surgical	103
Florida			
Brooksville	Brooksville Regional Hospital	General Medical/Surgical	91
Crystal River	Seven Rivers Regional Medical Center	General Medical/Surgical	128
Dade City	Pasco Regional Medical Center	General Medical/Surgical	120
Greater Haines City	Heart of Florida Regional Medical Center	General Medical/Surgical	115
Key West	Lower Keys Medical Center	General Medical/Surgical	167
Lehigh Acres	Lehigh Regional Medical Center	General Medical/Surgical	88
Marathon	Fishermen's Hospital	General Medical/Surgical	58
Milton	Santa Rosa Medical Center	General Medical/Surgical	129
Orlando	University Behavioral Center	Psychiatric	80
Punta Gorda	Charlotte Regional Medical Center	General Medical/Surgical	156
Sebastian	Sebastian River Medical Center	General Medical/Surgical	52
Sebring	Highlands Regional Medical Center	General Medical/Surgical	129
Spring Hill	Spring Hill Regional Hospital	General Medical/Surgical	126
Tequesta	Sandy Pines	Psychiatric	75
Georgia			
Monroe	Walton Regional Medical Center	General Medical/Surgical	135
Statesboro	East Georgia Regional Medical Center	General Medical/Surgical	150
Kentucky			
Paintsville	Paul B. Hall Regional Medical Center	General Medical/Surgical	72
Mississippi			
Biloxi	Biloxi Regional Medical Center	General Medical/Surgical	153
Brandon	Rankin Medical Center	General Medical/Surgical	134
Canton	Madison Regional Medical Center	General Medical/Surgical	67
Clarksdale	Northwest Mississippi Regional Medical Center	General Medical/Surgical	195

Exhibit 11/4: (*cont'd*)

Location	Hospital	Facility Type	Licensed Beds
Jackson	River Oaks Hospital	General Medical/Surgical	110
Jackson	Women's Hospital at River Oaks	General Medical/Surgical	111
Jackson	Central Mississippi Medical Center	General Medical/Surgical	473
Meridian	Riley Hospital	General Medical/Surgical	180
Natchez	Natchez Community Hospital	General Medical/Surgical	101
Missouri			
Kennett	Twin Rivers Regional Medical Center	General Medical/Surgical	116
Poplar Bluff	Poplar Bluff Regional Medical Center – North and South	General Medical/Surgical	423
North Carolina			
Hamlet	Sandhills Regional Medical Center	General Medical/Surgical	64
Louisburg	Franklin Regional Medical Center	General Medical/Surgical	85
Mooresville	Lake Norman Regional Medical Center	General Medical/Surgical	105
Statesville	Davis Regional Medical Center	General Medical/Surgical	149
Oklahoma			
Durant	Medical Center of Southeastern Oklahoma	General Medical/Surgical	120
Midwest City	Midwest City Regional Medical Center	General Medical/Surgical	247
Pennsylvania			
Carlisle	Carlisle Regional Medical Center	General Medical/Surgical	200
Lancaster	Community Hospital of Lancaster	General Medical/Surgical	154
Lancaster	Lancaster Regional Medical Center	General Medical/Surgical	261
South Carolina			
Gaffney	Upstate Carolina Medical Center	General Medical/Surgical	125
Hartsville	Carolina Pines Regional Medical Center	General Medical/Surgical	116
Tennessee			
Jamestown	Jamestown Regional Medical Center	General Medical/Surgical	85
Lebanon	University Medical Center	General Medical/Surgical	257
Tullahoma	Harton Regional Medical Center	General Medical/Surgical	137
Texas			
Mesquite	Medical Center of Mesquite	General Medical/Surgical	176
Mesquite	Mesquite Community Hospital	General Medical/Surgical	172
Virginia			
Pennington Gap	Lee Regional Medical Center	General Medical/Surgical	80
Washington			
Yakima	Yakima Regional Medical & Heart Center	General Medical/Surgical	226
Toppenish	Toppenish Community Hospital	General Medical/Surgical	63
West Virginia			
Williamson	Williamson Memorial Hospital	General Medical/Surgical	76

Source: Company documents.

services, intensive and cardiac care, plus emergency services that were staffed by physicians at all times. At various facilities, other specialty services, such as full-service obstetrics, oncology, and industrial medicine, were available. In addition, HMA operated two free-standing psychiatric hospitals.

Selected Financial Data and Operating Statistics

In 2004, HMA had a net income of $325 million on net patient service revenues of $3.2 billion and had shown consistent growth from 1999, when net income was $150 million and revenues were $1.36 billion. Total admissions rose 20.9 percent over fiscal year 2004, reflecting the admission contributions from hospitals acquired during the year. Patient days grew to 1.28 million in fiscal year 2004. Net patient revenues of hospitals that operated for at least 12 months increased by 3.7 percent during the fourth quarter of fiscal year 2004. Exhibit 11/5 shows the income statement and balance sheet for HMA.

Exhibit 11/5: Health Management Associates, Inc. Consolidated Statements of Income and Balance Sheets (in $ thousands, except per share data)

	Years ended September 30			
	2001	**2002**	**2003**	**2004**
Net Patient Service Revenue	1,879,801	2,262,601	2,560,576	3,205,885
Costs and Expenses				
Salaries and Benefits	710,535	874,729	989,075	1,259,859
Supplies	535,926	650,852	741,487	956,891
Provision for Doubtful Accounts	143,923	172,430	186,826	240,074
Depreciation and Amortization	90,646	95,328	109,864	134,915
Rent Expense	40,850	47,048	50,401	65,766
Interest, Net	19,970	15,543	14,915	16,184
Write-off of Deferred Financing Costs	—	—	4,931	—
Noncash Charge for Retirement Benefits and Write-Down of Assets Held for Sale	17,000	—	—	—
Total Costs and Expenses	1,558,850	1,855,930	2,097,499	2,673,689
Income Before Minority Interests and Income Taxes	320,951	406,671	463,077	532,196
Minority Interests in Earnings of Consolidated Entities	—	1,009	4,341	5,716
Income Before Income Taxes	320,951	405,662	458,736	526,480
Provision for Income Taxes	125,973	159,226	175,312	201,381
Net Income	194,978	246,436	283,424	325,099
Net Income per Share				
Basic	0.80	1.02	1.19	1.34
Diluted	0.76	0.97	1.13	1.32

Exhibit 11/5: (*cont'd*)

	2002	2003	2004
Assets			
Total Current Assets	695,786	1,093,336	941,594
Net Property, Plant, and Equipment	1,281,782	1,427,715	1,692,701
Funds Held By Trustee	1,450	15,924	55,942
Excess of Cost Over Acquired Net Assets, Net	342,113	397,825	748,156
Deferred Charges and Other Assets	43,186	75,726	68,895
	2,364,317	3,010,526	3,507,288
Liabilities and Stockholders' Equity			
Total Current Liabilities	273,743	267,613	320,131
Deferred Income Taxes	17,861	80,023	143,760
Other Long-Term Liabilities	42,793	63,752	96,803
Long-Term Debt	650,159	924,713	925,518
Minority Interests in Consolidated Entities	33,009	37,350	43,066
Stockholders' Equity			
Preferred Stock	2,611	2,627	2,660
Additional Paid-in-Capital	373,214	399,782	445,270
Retained Earnings	1,271,583	1,535,322	1,830,736
	1,647,408	1,937,731	2,278,666
Less: Treasury Stock, 22,500 Shares at Both September 30, 2003 and 2002, Respectively	(300,656)	(300,656)	(300,656)
Total Stockholders' Equity	1,346,752	1,637,075	1,978,010
	2,364,317	3,010,526	3,507,288

Source: *Health Management Associates, Inc. 2004 Annual Report.*

Riverview Regional Medical Center

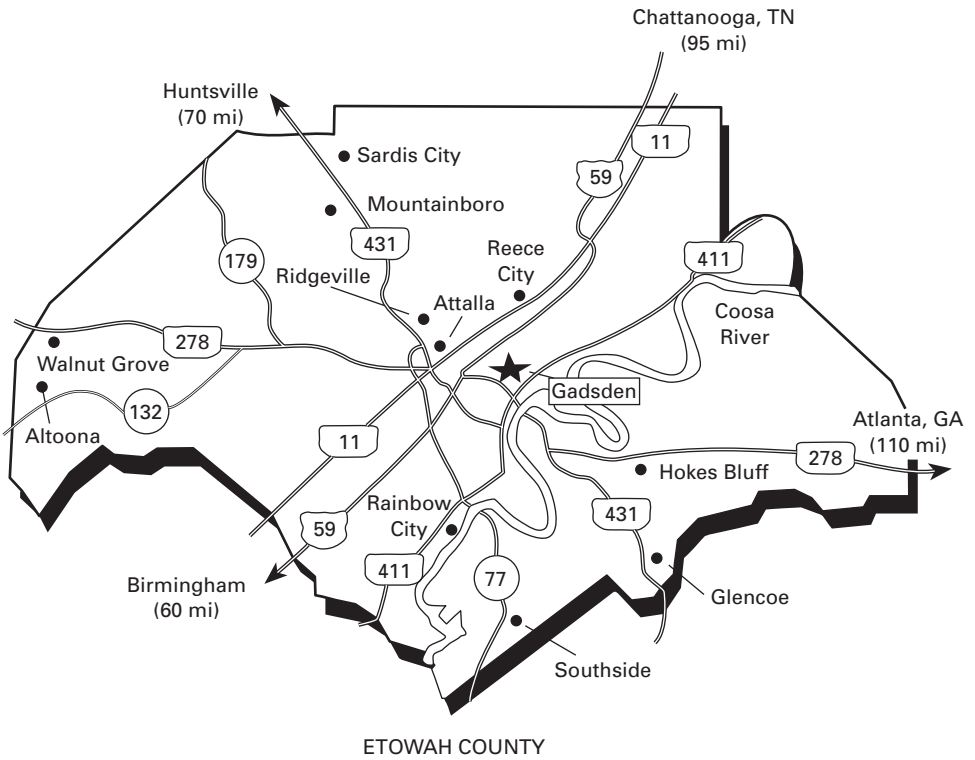
The 281-bed acute care facility was originally chartered as The Holy Name of Jesus Hospital, and was the first hospital built in Etowah County back in the early 1930s. Owned and operated by an order of Catholic nuns, it remained under their ownership and control until financial considerations persuaded them to sell the hospital to HMA in August 1991. At that time the name changed to Riverview Regional Medical Center. RRMC's mission statement was as follows:

> Riverview Regional Medical Center will provide services to the best of our ability, treating everyone with dignity and respect in a safe manner.

Local Demographics

RRMC was located in the city of Gadsden, Etowah County, in northeastern Alabama. Exhibit 11/6 shows the relationship and proximity of the cities of Etowah County as well as the county seat. Etowah County comprised 12 incorporated cities with a

Exhibit 11/6: Relationship and Proximity of Cities in Etowah County



Source: *Birmingham News* (January 25, 1991), p. A12.

total population of 103,459 people in 2000.[4] Gadsden was the largest city (population 38,978) in Etowah County as well as the county seat (see Exhibit 11/7).

Gadsden was a transportation hub connecting many of the major metropolitan areas in the southeastern region of the country. It was located at the southern foothills of the Appalachian Mountains in an area 60 miles northeast of Birmingham, 70 miles southeast of Huntsville, 110 miles west of Atlanta, and 95 miles southwest of Chattanooga. Situated astride Lookout Mountain and the Coosa River, the city had grown from sparsely populated Indian country in the early 1800s to a city with a population that peaked at more than 58,000 residents in the early 1960s. Exhibit 11/8 shows the demographic makeup of Etowah County and Exhibit 11/9 shows the population of the surrounding counties.

Health Care Competition

Unlike many of the other facilities operated by HMA, RRMC was neither the sole community provider, nor even the dominant provider of health care in the

Exhibit 11/7: Population Trends, Etowah County/Gadsden 1960–2000

County/City	1960	1970	1980	1990	2000
Etowah County	92,980	96,980	103,057	99,840	103,459
Altoona	744	781	928	960	969
Attalla	8,257	7,510	7,737	6,859	6,952
Gadsden	58,088	53,928	47,565	42,523	38,978
Glencoe	2,592	2,901	4,648	4,670	5,143
Hokes Bluff	1,619	2,133	3,216	3,739	4,149
Mountainboro	—	311	266	261	338
Rainbow City	1,626	3,107	6,792	7,673	8,428
Reece City	470	496	718	657	634
Ridgeville	—	—	182	178	158
Sardis City	—	368	883	1,301	1,438
Southside	436	983	5,139	5,580	6,906
Walnut Grove	237	224	510	717	710

Source: http://www.census.gov/main/www/cen2000.html

Exhibit 11/8: Population Demographics

	1990	2000
Gadsden Population	42,523	38,978
County Population	99,840	103,459
Male	45.1%	46.0%
Female	54.9%	54.0%
White	70.5%	62.7%
Black	28.1%	34.0%
Under 5	6.3%	6.6%
65 or over	20.3%	22.1%
Median Household Income	$19,187	$24,823

Source: Gadsden Area Chamber of Commerce.

Exhibit 11/9: Population of Surrounding Counties

County	Area (sq. miles)	Population	County Seat	Workforce
Blount	643	51,024	Oneonta	23,896
Calhoun	611	112,249	Anniston	51,402
Cherokee	553	23,988	Centre	10,607
DeKalb	778	64,452	Fort Payne	30,903
Etowah	542	103,459	Gadsden	46,225
Jefferson	1,119	662,047	Birmingham	317,658
Marshall	567	82,231	Guntersville	38,900
St. Clair	646	64,742	Ashville	29,492

Source: http://censtats.census.gov/cgi-bin/pct/pctProfile.pl

market service area. Gadsden Regional Medical Center (GRMC), with 248 beds in service (346 licensed beds), offered considerable competition for RRMC. Both acute care hospitals were among the nine largest employers in Etowah County. Unlike the key GRMC medical staff members, who were housed in a hospital-owned professional office building, RRMC's key medical staff members and group practices maintained separate offices throughout the city. For the most part, the two hospitals had a common medical staff membership, with the exception of the Emergency Department and radiology physicians.

Primary Market Area

Although not owned by the Goodyear Tire and Rubber Company (Etowah county's largest employer and fourth largest taxpayer), GRMC was located on property adjacent to the Goodyear plant. The hospital, formerly known as Baptist Memorial Hospital, was sold to Quorum Health Group/Quorum Health Resources and renamed Gadsden Regional Medical Center in 1993. In April 2001, Triad acquired Quorum for $2.4 billion in cash and securities, creating the third largest investor-owned hospital chain in the United States.

Both RRMC and GRMC were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), certified for participation in the Health Insurance for the Aged (Medicare) Program by the DHHS, and contracted or participated in Blue Cross Plans as reported by the Blue Cross Association. However, only GRMC had a cancer program approved by the American College of Surgeons. In addition, GRMC offered neurosurgery, psychiatry, and obstetric services not offered by RRMC. For a comparison of the two facilities see Exhibit 11/10.

Another local provider of health care services was Mountain View Hospital, a psychiatric and chemical dependency facility for children, adolescents, and adults. Although by virtue of its target population Mountain View Hospital was

Exhibit 11/10: Facility Comparison

Category	RRMC[a]	GRMC[b]
Number of Beds	281	248
Number of Admissions	9,710	11,074
Census	129	135
Outpatient Visits	55,340	51,195
Births	*	1,163
Payroll (in thousands of dollars)	30,500	29,589
Personnel	850	939

*Obstetric services discontinued April 2003; 433 births between October 2002 and March 2003.

[a] ***Source:*** Riverview Regional Medical Center.

[b] ***Source:*** *AHA Guide to the Health Care Field*, 2003–04 edn (Chicago, IL: American Hospital Association, 2003).

not a direct competitor of RRMC, it nonetheless influenced the local market forces with respect to certain health care services.

Mountain View Hospital implemented professional and educational programs by recruiting national specialists in the field of mental health. Through a relationship with Northeast Alabama Psychiatric Services, neuropsychiatry was available as well as extensive outpatient services. In addition, the hospital specialized in treatment of attention deficit/hyperactivity disorders in children and adolescents. In June 1991, an adult psychiatric unit opened to treat depression, stress, anxiety, and panic disorders. An intensive care center for psychiatric care opened in January 1993. Other services provided by Mountain View Hospital included substance abuse treatment, a year-round academic program, a state licensed private school for inpatients, partial hospitalization, community education, and free 24-hour crisis evaluation. Physicians were being recruited from various nationally respected hospitals throughout the country with specialized areas of expertise in the field of mental health.

HealthSouth, one of the nation's largest providers of inpatient and outpatient services, operated rehabilitation and outpatient surgery facilities in Gadsden. In combination, these facilities offered a continuum of services, including acute medical care, inpatient rehabilitation, subacute care, day hospital, outpatient rehabilitation, home care, outpatient surgery, diagnostic imaging, and occupational medicine. In all, more than 30 medical specialties were available.[5] Many of the community physicians were part owners of the HealthSouth outpatient surgery facility; thus, they had a financial incentive to favor the facility over the hospital-based outpatient surgery units.

The HealthSouth Corporation was rocked by a multibillion dollar accounting scandal when it was accused of overstating its earnings in an effort to meet Wall Street expectations and bolster the stock price. Seventeen executives pleaded guilty to accounting fraud and violation of the Sarbanes-Oxley Act during the investigation.[6] The founder and CEO, Richard Scrushy, maintained his innocence but the board of directors forced him out of the company in March 2003. His trial on the 85-count indictment handed down in November 2003 began in March 2005.

RRMC increased its presence in nearby Anniston. In fact, one cardiologist had his primary care practice in Anniston, but sent his angioplasty patients to RRMC. With the military Base Realignment and Closure (BRAC) of Fort McClellan's Noble Army Base Hospital, RRMC was successful in obtaining the government contract for Tri-Care, thus bringing the area's military retirees to RRMC for service. HMA was present in Anniston through its ownership of Stringfellow Memorial Hospital, as well.

Out-migration to Birmingham

None of the hospitals in Gadsden could ignore the opportunity for residents to travel outside the local area for nonemergency care. Gadsden's proximity to the interstate network facilitated out-migration to urban areas boasting larger medical facilities. Although exact figures were unknown, the volume was estimated to be in excess of 25 percent. The Birmingham metropolitan area included

approximately 20 hospitals, many of which offered specialty programs attractive to individuals who were predisposed to self-select health care services. Among those hospitals were HealthSouth, Baptist Medical Centers, St. Vincent's Hospital, Carraway Methodist Medical Center, Children's Hospital of Alabama, Brookwood Medical Center, the Eye Foundation Hospital, the Veterans' Administration Medical Center, and the University of Alabama at Birmingham (UAB) Medical Center.

The UAB Medical Center campus was located approximately one hour's drive from Gadsden via Interstate 59. It was a world-renowned patient care, education, and research complex, comprising: the Schools of Medicine, Dentistry, Nursing, Optometry, Health Related Professions and Public Health; the University of Alabama Hospital; and several of the specialty hospitals mentioned above. The University of Alabama Hospital, a 903-bed teaching facility with more than 50 clinical services, dominated the Medical Center. University Hospital encompassed the Alabama Heart Hospital, the Lurleen Wallace Complex for comprehensive cancer treatment, Spain Rehabilitation Center, and the Diabetes Hospital. More than 25 educational, instructional, and patient care "centers of excellence" and approximately 20 specialty units providing treatment, screening, and laboratory services were sponsored by the hospital. The UAB Hospital was consistently ranked as one of America's best hospitals by *U.S. News & World Report*.[7] In 2004, UAB ranked 6th in rheumatology, 13th in kidney disease, 17th in gynecology, and 19th in cancer. In all, *U.S. News & World Report* ranked 14 UAB programs in the top 50 for 2004. The medical staff (faculty for the UAB School of Medicine) practiced privately in the Kirklin Clinic, an ultramodern, high-technology facility that opened in 1992. The multispecialty Kirklin Clinic marketed aggressively throughout and beyond the Birmingham market area.

Operational Challenges at RRMC

HMA named Matt Hayes as executive director of RRMC in October 2003. From 2000 to 2003, Mr. Hayes served as executive director of Stringfellow Memorial Hospital, an HMA-leased facility in Anniston, Alabama. He was intimately familiar with RRMC, having served as its associate executive director from 1998 to 2000. He held a Master of Health Administration from the Medical University of South Carolina as well as an MBA from the University of Alabama at Birmingham.

Mr. Hayes faced many challenges in accepting the executive director's position at RRMC. First, his predecessor closed the Women's Pavilion in March 2003. Despite having a strong patient load, the unit was losing money because of its inability to capture the vast majority of births in the county and changes in reimbursement relating to disproportionate share monies. The decisions to close the Women's Pavilion and discontinue obstetrics created a perception in Gadsden that RRMC was in financial distress. Furthermore, the closing of the facility strained the relationship between management and the medical staff. Mr. Hayes established the Physicians' Leadership Group to improve communications with the medical staff. The group consisted of 25 core physicians that met quarterly. The goal was

for this group to have more time to plan strategically, thereby minimizing implementation issues related to physician buy-in to changes at RRMC.

Physical Plant Changes at RRMC

The physical plant was originally constructed in 1931, with major additions in 1965 and in the 1970s. The acquisition of the hospital by HMA in 1991 ushered in more large-scale changes. By 1997, the facility had completed a $2 million renovation project that began with the hospital's entrance and included the emergency department (ED). The completely remodeled ED paralleled a level of medical sophistication usually observed only in larger urban hospitals. The ED was expanded to 18 patient treatment rooms with monitoring capabilities that included hardwire and telemetry electrocardiograms, noninvasive blood pressure measurement, noninvasive arterial blood gases, respiratory rate, and temperature. The ED was supported by a full-service, fully equipped 24-hour lab and state-of-the-art CT and ultrasound imaging units.

In 1994, HMA purchased the Medical Arts Building a few blocks from the hospital. Several of the older physician practices were located in this building and they had been reluctant to make technological and appearance upgrades. Thus, as tenants moved out, new tenants were hard to attract. HMA purchased the property, made some renovations, and leased the office space to physicians.

The hospital (when it was still Holy Name of Jesus) had an obstetrician with office space in the hospital. RRMC honored his lease until it expired in the mid-1990s, then turned the space into a separate entrance (rather than having outpatients enter through the ED, as was the old procedure). On his arrival, Mr. Hayes concluded, "Outpatient procedures aren't patient friendly. MRI and CT are on the first floor; outpatient registration is on the third floor; and the lab is on the second floor."

In August 2004, RRMC purchased the operations of a diagnostic center. The center was housed in a leased building one mile south of the hospital on the river. Mr. Hayes said, "Our goal is to have a full-blown diagnostic center with fast patient turnaround. The facility has an open MRI and a CAT scan scheduled to open by the end of the year. A PET scan will be available as a physician joint venture with the building landlord. Patients will perceive the PET as an HMA service since operations will be seamless, but the joint venture will hold the financial burden of the equipment."

Mr. Hayes commented, "The ED is the 'front door' for the facility because it accounts for nearly 60 percent of total admissions. We have initiated aesthetic renovations of the area over the past year and replaced the ED nurse manager to improve patient satisfaction." After renovating the ED in 1996, annual patient visits had increased from 23,000 to 26,000. In 2004, ED visits totaled over 24,000.

A Chest Pain Center was created across the hall from the ED, partially in response to the number of patients entering the ED complaining of chest pains (see Exhibit 11/11). There were ten beds in the Chest Pain Center; patients moved

Exhibit 11/11: Top Ten "Chief Complaints" in Riverview's Emergency Department, FY 2004

Chief Complaint	Number of Visits*
1. Chest Pain – Atraumatic	1,582
2. Abdominal Pain	1,509
3. Back Pain	1,131
4. Shortness of Breath	875
5. Fall	795
6. Nausea/Vomiting/Diarrhea	766
7. Headache – Frequent, with history	511
8. Knee Injury	353
9. Ankle Injury	346
10. Multiple Contusions	324

*Data from September 2004 not available.

there after ED triage for tests and cardiac rule-out. Cardiac-diagnosed patients were transferred to the cardiac cath lab or admitted as inpatients. Evaluating ED patients with chest pain through the Center decreased the length of stay (LOS) in the ED to 3.25 hours. Although the national average for ED LOS is between four and five hours, the RRMC ED LOS is still above the HMA average of 2.0 hours, which is the ultimate goal.

The closing of the Women's Pavilion left a $3 million building vacant. Mr. Hayes stated, "I considered outpatient surgery, GI/endoscopy, and cardiac services as potential uses for the building. Ultimately, I decided to focus on what we do best." He continued, "The Heart and Vascular Center, a facility totally dedicated to cardiology, opened in October 2004. It has nine holding beds to serve the two cardiac catheterization labs and seven 23-hour beds. The building does have space for a third catheterization lab – if it's needed and we can get a CON. The old C-section suite is now the cardiac procedure room. If a patient needs immediate open heart surgery, the Center is connected to the open heart surgery suite by elevator."

In addition to these changes, all 180 patient rooms were converted to private occupancy, requiring major renovations to the 281 licensed-bed facility. This conversion occurred between April and August of 2004. Mr. Hayes contracted to have the exterior of the hospital painted to improve the community's "first impression" of RRMC.

Innovative Programs

In addition to the Heart and Vascular Center, RRMC opened the Heartburn Treatment Center. Hayes commented, "Do you realize that one out of every 14 Americans has severe, chronic heartburn? In fact, the American Gastroenterological

Association reports that heartburn affects more than 60 million people. Our Heartburn Treatment Center utilizes a nurse manager similar to the management model employed in the ED. One of our diagnostic procedures involves pH monitoring using the Bravo capsule.[8] If surgery is indicated, the 'lap Nissen' procedure[9] is performed at the hospital. Unfortunately, the manufacturer of the capsule has been unable to keep up with demand and the Center is only receiving two to four capsules per week. We could use twice as many each week."

Targeted at potential patients, the "Nurse First" program emphasized RRMC's commitment to patient care. The first person a patient saw in the ED was a nurse, not someone from the registration department. The ED utilized a computerized protocol system approved by an emergency department physician that aided in the triage of patients.

Targeted at physicians, the "One Call Scheduling" program attempted to simplify the admission process for physicians. The admitting physician called a dedicated number at RRMC, where staff could schedule appointments with any department at RRMC (preadmission testing, anesthesia, surgery scheduling, and so on).

Aimed at individuals and potential employers, the MedKey system employed computer technology to streamline patient registration and admission procedures with a plastic "smart card" containing a magnetic strip on which pertinent patient information was encoded and updated quickly and easily, as necessary. MedKey translated into increased operational efficiency and better service for patients by substantially decreasing the amount of time required to process an admission and record insurance coverage. HMA had over one million MedKey cards in use in 2004. All of the above programs portrayed a patient- and physician-oriented image.

Marketing

Subsequently, the MedKey system was a focused marketing strategy that used the patient database to promote RRMC facility utilization through membership incentives and rewards via discounts and extra services for MedKey "members." Marketing efforts were directed at recruiting potential individual members as well as employer-group memberships. As a marketing vehicle, Mr. Hayes viewed MedKey as more effective and cost efficient than mass advertising.

An in-house newsletter featuring new and existing programs and services as well as new benefits for MedKey members was developed and mailed on a regular basis. Promotional flyers were developed and mailed to inform members of upcoming events and activities.

The MedKey program created a win/win/win situation for area businesses, RRMC, and MedKey members. The hospital would win by improving its membership incentives through the discounts provided by the co-sponsoring enterprises. The companies would win by reaching a larger market through the hospital's direct-mailings to the ever-growing list of MedKey members to promote upcoming events, new services, and membership discounts. The members would

win by receiving savings on services at RRMC as well as savings on the products and services of co-sponsoring enterprises.

A relatively new marketing tool for RRMC was the Internet. Its website made the hospital's programs and events easily accessible to current and prospective patients and staff. Of course, the competition offered websites as well.

As part of an ongoing image campaign, RRMC was filming a commercial. According to Mr. Hayes, "The basic message is that we've served the health care needs of the community since 1926 and will continue to do so for years to come." He continued, "The commercial combined with our campaigns on our new service lines and HealthGrade rankings should reflect positively on our image in the community. It also makes it easier to tell the RRMC story when I visit health fairs and speak to civic groups."

Operations

The hospital employed approximately 700 people, including nurses and housekeeping staff. The dietary department was contracted out. A local rather than a national vendor provided the laundry service. This decision allowed for a perceived luxury amenity in that the hospital had monogrammed towels as opposed to those with the stamped-on hospital logo available from national vendors.

In an effort to achieve a quality-driven level of patient-focused care, the patients' room telephones provided direct lines to the nurse manager, housekeeping, and food service (in the event of an error in dietary restriction meals). This allowed for direct contact to the service provider rather than waiting for information to pass through a chain of command.

Future Challenges for RRMC

Ongoing reimbursement issues presented a constant challenge for all health care administrators. Medicare reimbursement for Alabama was the lowest rate in the nation. Over 65 percent of Alabama hospitals were operating "in the red." The rumor among state health care leaders was that the Alabama Medicaid program would decrease beneficiary coverage from 16 inpatient days per year to 12 per year because of funding issues. Eighty percent of RRMC's patients were Medicare or Blue Cross. In addition to the fixed pricing constraints inherent in Medicare, Blue Cross's monopoly prevented negotiations to achieve better rates for those patients.

Mr. Hayes knew that the Heartburn Center and Diagnostic Center were important steps in generating outpatient revenues. These centers, along with initiating the nurse manager positions, helped improve patient satisfaction. The opening of the Heart and Vascular Center in October 2004 was expected to bolster RRMC's reputation in the community. In fact, HealthGrades.com's fall 2004 ratings listed RRMC as the no. 1 cardiovascular surgery hospital in Alabama. HealthGrades recognized the hospital's orthopedics and stroke programs as well.

Despite the strong gains made in operational efficiencies and improved service lines, Mr. Hayes knew closing the Women's Pavilion was an unpopular decision with the community citizens and with the medical staff. Improving relations with these groups would have to be his focus in the immediate future. However, the corporate goal to improve further the efficiency of the ED "front door" and gaining market share for the newly opened Heart and Vascular Center needed his attention as well.

NOTES

1. Ernst and Young, *Health Management Associates, Inc., 1995 Annual Report*.
2. B. Japsen, "Investor-owned Chains Seek Rich Rural Harvest," *Modern Healthcare* 26, no. 27 (July 1, 1996), pp. 32–37.
3. Ibid.
4. "State of Alabama – 2000 Census" available at: http://www.ador.state.al.us/licenses/census.html, accessed September 11, 2004.
5. See http://www.healthsouth.com.
6. "Scrushy Accused of Plane Misuse," *Toronto Star* (July 3, 2004), p. D20.
7. "Best Hospitals 2004," *U.S. News & World Report*, http://www.usnews.com/usnews/health/hosptl/tophosp.htm, accessed September 13, 2004.
8. The Bravo capsule (microchip) was inserted in the esophagus via the throat to monitor and record acid reflux. After the data were retrieved from the monitor, the chip sloughed off and passed through the digestive tract. This technique was much more comfortable for the patient than the commonly used procedure of passing a probe through the nostril into the esophagus, and leaving the probe physically attached to an external monitor for 24 hours.
9. The "lap Nissen" procedure, or fundoplication, was used to control acid reflux by wrapping the upper portion of the stomach (the fundus) around the bottom of the esophagus. The procedure was performed laparoscopically through five small incisions instead of one large abdominal incision. Surgical trauma was lessened and recovery time shortened with laparoscopic procedures.