PGDM, 2019-21

Strategic Management II

DM-402

Trimester – IV, End-Term Examination: September 2020

Time allowed: 2 Hours 30 minutes
Max Marks: 50

Roll No: _____

Instruction: Students are required to write Roll No on every page of the question paper, writing anything except the Roll No will be treated as **Unfair Means.** In case of rough work please use answer sheet.

Note: There are 2 sections in this paper. Answer briefly and to the point.

Section A: Answer 3 Questions (10 marks each), 1 each from A, B, and C

Q. A.1 Strategic Planning has to be followed by Strategic Implementation. Explain the process of Strategic Implementation enunciating and describing the key variables and the enabling environment. **CILO 1, Develop a perspective for effective implementation` of strategies for creating sustained competitive advantage.**

Q. A 2 Do you think it makes sense for a firm to come out with a grand sounding Vision Statement which looks comprehensive, instead of focusing on the Business that it is in, and ought to be in? What are the key requirements of a Vision Statement, which will enable an exclusive and superior competitive position. Provide an example of a firm that has followed this. **CILO 1, Develop a perspective for effective implementation` of strategies for creating sustained competitive advantage.**

Q. B.1 Map the flow of a firm's Strategic Plan, from a Vision Statement through competitively advantageous and effective stages to ensure width and depth in the implementation. Provide one example of how this can and should be done **CILO 2. Establish the flow of strategy from organizational vision, core values, through key focus areas, putting appropriate systems for implementation, setting and achievement of targets.**

Q. B.2 .. Do you think that advanced hardware and software alone would ensure practical and effective Information systems for a firm and for Industry in general? If so, present the case. If not, what do you think are the key system fundamentals that should be established? **CILO 2. Establish the flow of strategy from organizational vision, core values, through key focus areas, putting appropriate systems for implementation, setting and achievement of targets.**

Q. C1 Describe the Leadership mantle of Timex Watches Ltd. What in your view were the differentiating aspects of the Leadership system. Was it authoritarian, suppressive or inclusive and supportive? Point out and and explain the outstanding features. Do you have any suggestions whereby the leadership could have been made even more effective? Justify them. **CILO 3. Creating a fit between Strategy and organizational structure and controls for smooth implementation of chosen strategy. Appreciate the vital importance of strategic leadership for effective implementation of chosen strategy.**

Q.C.2 Evaluate the Customer orientation and delivery of Customer Service at Timex. Where was/were the starting points? How did a systems approach help in enhancing the bond between the company and its Customers? Was the organization structure and functioning helpful in this endeavor? Provide instances and arguments to support your submission. **CILO 3. Creating a fit between Strategy and organizational structure and controls for smooth implementation Of chosen strategy. Appreciate the vital importance of strategic leadership for Effective implementation of chosen strategy.**

From Band Baja to Thali Bajao –Transitional Change in Bajaj Auto

Bajaj Auto was set up in 1945 by by Kamalnayan Bajaj son ofJamnalal Bajaj, a true patriot and an ambitious industrialist who was also the founder of the Bajaj group of Companies. Originally formed to import and sell two and three wheeler products the firm moved into Manufacturing and Marketing Scooters through a collaboration with Piaggio a lesser known Italian Scooter firm whose brand was Vespa. Led by Janmal's son Rahul Bajaj(one of India's earliest graduates from the renowned Harvard Business School, Bajaj Auto over a span of two decades became a virtual monopoly in the country's two wheeler space. In addition, the firm has dominated the 3 wheeler space, becoming the World's largest Manufacturer of these products as also the premier exporter from India. The firm which became a public limited entity in 1960 had impressive profit growth and was considered a darling of the country's stock market. Rahul Bajaj also pioneered India's Non Banking Financial Sector by innovatively lending to Corporates at higher rates than Banks utilising its large and growing Retained Earnings

While Rahul Bajaj deserves credit for lifting his firm to a pre-eminent position in India's 2 and 3 wheeler auto space, he has to bear responsibility for missed opportunities to maintain dominance in the 2 wheeler space and in becoming a prominent global player. Though all the World's leading 2 wheeler companies from Japan, were dying to enter India which they saw as a potentially huge market and chose Bajaj Auto as their preferred partner, Mr.Bajaj, placed such stringent conditions on the partnerships seeking dominance in every part of the business including financial holding, control of technology and Sales and Marketing, that none of them could persist in their wooing efforts. Finally Bajaj entered into a collaboration with Kawasaki Motors of Japan. This was an ill fated union, because Kawasaki occupies a very small part of the two wheeler market with light, expensive, high performance vehicles which are not suited for the Indian Mass Market. This partnership ended in 2017 which was to be seen as a "better late than never", move on the part of Bajaj Auto. Moreover, the Indian stalwart refused to see the inevitable rise of Motorcycles in the Indian market which would largely replace Scooters as the preferred form of 2 wheelers. The result was the Bajaj Auto slipped from an indisputable "Numero Uno" status to 5th position in the domestic 2 wheeler space, and was surpassed by the new kids on the block including Hero Motors and TVS Motors among others.

Beyond the Strategic errors, Rahul could also be held guilty of an extremely authoritarian leadership style. He openly stated that while he had hired and held many highly paid executives who worked from swank offices, all decision making was his, and his alone which could be summarised as "My way or the Highway" a colloquial expression for outright personal dominance in an Institution.

Enter the light weight Debutant: Rajiv Bajaj is the eldest son of Rahul Bajaj. Unlike his father he has had an Ordinary Academic Career graduating from a Pune India engineering college, and doing a Masters in Engineering from a low profile U.K. Institution. He joined his father's company in 1991 and worked for 14 years in various functions of the company When asked to take over by his now aged father, he placed a simple condition that the elder Bajaj would not interfere in the Management of the ailing two wheeler company. Once this was accepted, the young man got to work on revitalising the firm and making it a dynamic organisation getting eyes and ears of the industry and public popping regularly. Bajaj Auto made a significant "re-entry" into the Motorcycle space with a product called Pulsar which was a medium range bike(160-180CC) and was priced reasonably for its segment. Thereafter the Pulsar range has been progressively increased providing variety and reliability in its offerings.

The Killer Decision was to collaborate with a little known but exceptional Austro German Company KTM which had set up operations in India. Bajaj Auto took a share in this company. The collaboration has given much needed technology support to Bajaj Auto. The products that have come from the joint venture are high quality, high performance, reasonably priced offerings, whose major acceptance has come from foreign markets. It is a matter of pride for Rajiv and his company that exports have steadily increased and now count for 47% of the company's sales. This is particularly significant because the Automobile Industry in India has suffered a significant decline in

Sales in all its sectors including Cars, two wheelers and Commercial vehicles. Amidst this mayhem, Bajaj Auto has not just survived but grown in overall Sales. The company which relied on its Pune unit in Chinchwad- a pioneer industrial extension of the city-has set up additional manufacturing facilities in other cities. As a strategic decision, the move to additional locations is not just sound but brilliant, because the firm can benefit from reduced labour(read organised union labour) problems in new locations.

The Who and What of the Managing Director: Rajiv Bajaj belongs to an illustrious business family and his predecessors have not only contributed to India's freedom struggle that brought Independence (Jamnalal Bajaj provided financial and moral support to Gandhi).

The Inheritance of Rajiv Bajaj: Bajaj Auto had sunk considerably in its market share and profitability at the time Rajiv assumed the top position. He has shown himself to be an objective thinker, a person who relies on good advice from his colleagues, and a decisive leader who has not been averse to taking tough calls where the uncertainty in the environment has been significant. The results speak for themselves. Bajaj Auto has regained a significant part of its lost market share in the 2 wheeler industry. It has created a distinct high tech image of providing advanced design and engineering which have resulted in products with superior performance delivered at Competitive prices. He relies a lot on his top management team comprising a handful of functional experts who have earned their spurs and built a world class company over the many years that they have spent as loyal employee stakeholders

If there is one person who is prepared to touch on sensitive topics and speak his mind, it is none other than Rajiv Bajaj. He comes out with measured analysis and objective remarks. During the current Covid pandemic, while all other Industrialists have been singing paeans of praise for the decisions made by Central authorities, Rajiv has made his reservations public about the serious economic loss caused by repressive lockdowns with inadequate provisions for routine adversities and lack of attention to contingencies. No other business leader has come out with similar feedback. It is to be noted that Bajaj Auto was one of the first companies in the Country who resumed Manufacturing operations with close to full strength. It would be obvious that there had been meticulous planning behind this, and other noteworthy initiatives including maintaining the tempo of Exports. In the arena of Atmanirbhar which the country is expected to establish and grow from, the shining example of this company which has focused on Exports(Bajaj Auto exports as a share of its turnover is 47% compared to less than 10% of the market leader Hero Motors.

While no body in the company comes out with grand claims of success and the reasons behind the same, the firm is a tightly knit team of top and senior managers who take responsibility for their respective functions and contribute to collective decision making, formulation of plans and timely and effective implementation. The future for the firm certainly seems bright.

Q.1. From the facts provided in the Case, describe the Leadership System in the newly charged Bajaj Auto organisation. What facets of leadership does Rajiv Bajaj reveal. Do you think that Courage, bold decisions can only be a force vector, of authoritarian leadership. In your view does graduating from a World renowned Business School ensure outstanding corporate performance, or is it likely to compromise it? Strengthen your submission with simple logical arguments. **10 Marks**

Q.2. What can be assessed and concluded about the Strategic Planning and Implementation at the reformed and invigorated company that Bajaj Auto has become. Which of the levers-Context, Systems and Action has been used to the greatest extent. Justify your answer with facts and reasonable conclusions from the Case material. Can it also be said that all the levers have been judiciously activated? Provide evidence and projections from the Case. **10 Marks**

PGDM, 2019-21

Strategic Management-II

DM-402

Trimester – IV, End-Term Examination, September 2020

Time allowed: 2 Hrs 30 Min Max Marks: 50

Roll No: _____

Notes: 1. Please type your answer by each question starting new page, or as recommended by examination office. Use frameworks taught in the class wherever possible. The paper contains total of 10 pages, including 8 pages of the Case study.

2. Attempt all 5 questions but can choose between 1a&1b, 2a&2b, 3a&3b. Questions 4-5 are compulsory

3. The weightage of the exam is 50 marks in the grading

4. Follow submission guidelines issued by Examination Department

5. The total time allowed for exam is 2 hours

SECTION A

Note. Attempt either a or b question from the each of the 3 questions given below

Q 1a. Under what condition the Lead independent director is appointed and what should be his role in making the Board of Directors more responsive to stakeholder.? (CILO 1) **MM:10**

OR

Q1b. What is corporate governance and how is it used to monitor and control managers' decisions, considering the agency relationship between the two? (CILO 1) **MM:10**

……

Q 2a Discuss the difference between strategic and financial controls and the context in which they are employed. (CILO 2) MM:10

OR

Q2b Describe the Organizational structure that are suitable for differentiation Strategy in the light of organizational structure design principles ? (CILO 2):**MM: 10**

……..

Q3a What is a top management team, and how does it affect a firm's performance and its abilities to innovate and design and implement effective strategic changes? (CILO 3); **MM:10**

Q3b. What is organizational culture? What must strategic leaders do to develop and sustain an effective organizational culture? MM 10 (CILO 3)

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SECTION B

Note. Attempt all Questions related to the case study on **Franklin Health Associate (A),** which is attached with this paper

Q4. Analyze the Strategy of the case Franklin Health Associates (A), including its product-market offering, consistency across businesses and potential for gaining and sustaining competitive advantage MM 10 (CILO, 1,2,3)

Q5. Analyze the strengths and weaknesses of the organizational structure to consistently execute its strategy well. Propose revised structure that would better align with the strategy of Franklin Health Associates (A)

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Franklin Health Associates (A)

> We've worked through a lot of problems and I've made some changes in the organization. We're at a juncture now, and we need to think ahead. I'm concerned about whether we can shift to a more progressive and less reactive posture.

The speaker was Paul Johnson, Executive Director of Franklin Health Associates (FHA). Located in Farmington, Maine, FHA had been undergoing a period of rapid growth, and Mr. Johnson wondered whether the organization's existing management structure and systems were appropriate to meet its needs in the future.

BACKGROUND

FHA was established in 1971 in the midst of a "hospital war" between two groups in West Central Maine. After each applied separately for Hill-Burton money and was rejected, the two groups were compelled to cooperate and compromise on the hospital's Farmington site.

At about the same the time, four physicians practicing out of the nurses home of the old hospital began an affiliation with the Community Action Program, funded by the Federal Office of Economic Opportunity. They documented the need for improvement in the geographical and financial access to health care for the 30,000 residents who lived in the 27 rural townships in the nearby mountainous and heavily forested areas. FHA was set up to help fill this need, and was awarded a two-year federal grant. For the next two decades, the organization thrived in an environment of cost-based reimbursement and generous federal support for its outreach programs.

Mr. Johnson had become FHA's executive director about four years ago. At that time, according to him,

> ... the organization had no logical or deliberate planning. It was separated into the three divisions of Franklin Group Practice [FGP], Franklin Area Health Plan [FAHP], and Research and Development [R&D]. The separation had occurred as a reactive stance, however. The corporation had grown unwieldy and there was infighting over the budget and public image.

ORGANIZATIONAL GOALS AND STRUCTURE

FHA was chartered to develop a group practice, a prepaid health plan and minibus transportation system for the poor, and a research program. Its goals included:

1. The area-wide delivery of comprehensive primary medical care with continuity and a strong preventive emphasis.
2. The recruitment of only board-certified or board-eligible physicians.
3. Peer review and audit, especially in the outpatient setting.
4. The necessity for and support of continuing education of its providers.
5. The teaching of pre-doctoral and postdoctoral health professions students.
6. Research and demonstration projects in clinical areas, health services delivery, health education, and nutrition.

This case was prepared by Margaret B. Reber under the direction of Professor David W. Young. It subsequently was revised by Professor Young. It is intended as a basis for class discussion and not to illustrate either effective or ineffective handling of an administrative situation.

In addition to Mr. Johnson, FHA's key staff included Ron McMahon, controller, Dave Donnelly, medical director, and Jack Barber, FGP's business manager. Mr. Johnson also served as director of FAHP and R&D. In addition, there was an executive committee composed of three elected providers.

FHA had a 15-member board of directors, with 8 consumers and 7 providers. The board had a standing committee on goals and objectives, which Mr. Johnson had established when he became executive director. According to him:

> The committee has met off and on over the past few years, and we have another meeting next week. We need to start thinking ahead and plot where the need is going to be. For example, at the time we started FHA, there were 13 physicians in the region. Six of them are still here, but now the total is 24, 12 of whom practice at FHA. They are all young and about the same age. In fact, at age 51, I'm the oldest member of this organization. If we don't phase the M.D.s, they'll all be retiring at about the same time and we'll have a shortage all over again.
>
> Very few of the M.D.s are native "Maineiacs." There are many people who want to leave Boston and other big cities. Last week we had a husband and wife team from Cleveland who were interested in moving up here. Physicians get tired of the routine office work and the isolation and overload of solo practice. Some want to get away from being the 24-hour-per-day country doctor. They want to share records and coverage, and get professional stimulation.
>
> The physicians also seek challenges, and are attracted by our R&D activities and FAHP alternative delivery project. Recently, I encouraged one of our physicians, who was bored with day-to-day activities, to submit a grant. Now he has funding to examine early intervention with emotionally disturbed kids. Motivation for some physicians is money; for others it's free time. In terms of quality, we don't take a back seat. In no rural setting will you find more talent. The M.D.s have been well trained and are all board certified.

Franklin Group Practice

FGP was a group practice that provided medical, optometry, and dental services to about 60 percent of the people living in the service area. Its services were provided through five departments: Family Practice/Pediatrics, Internal Medicine, Surgery, Dentistry, and Optometry. There were three internal medicine specialists, three family practitioners, one pediatrician, one otolaryngologist, a general surgeon, an orthopedic surgeon, two dentists, and one optometrist. In addition, there were two physician assistants, one nurse practitioner, one dental hygienist, and one optometrical assistant. An organization chart is contained in Exhibit 1. As Mr. Johnson explained:

> There are no formal or informal department heads because we are trying to maintain an overall group identity. Ideally, however, I'd like to see FGP expanded to 15 physician providers. We need two more family practitioners, who would help spread our costs over a broader base and also provide more personal care. In addition, we could have more flexible scheduling and provide better weekend coverage.
>
> Every time a new physician joins the group we have a publicity release. We reiterate the hours and types of services offered. In general, we have real problems with our marketing. We can't use an objective form of marketing; we have to have a more personal form. An advertisement in the newspaper would have an impact like a sledge hammer on the head. So we try to use indirect means, like cooperation with area agencies. For example, we have a blood pressure program for the Bass Shoe Company employees, and this week I'm speaking at the Rotary Club. The physicians also contribute to the marketing of the group practice through their professional relations with various individuals and organizations.

For several years, FGP had attempted to reach many patients through the use of three satellite clinics located in secluded sections of Maine's western mountains. However, the clinics were never able to break even financially. In two cases, physicians practiced at the satellite clinic just long enough to build up a practice and then they left. As a result, only one satellite was left, located in Rangeley.

Franklin Area Health Plan

FAHP was an individual practice association (IPA) health maintenance organization, designated as a foundation. It provided comprehensive, prepaid health care to 2,700 poverty-income level and 500 commercial residents in the area. Ninety percent of each low-income enrollee's premium was paid by the state of Maine through a managed care initiative in its Medicaid Program. Mr. Johnson reflected on the difficulty of marketing to the commercial segment of the market:

FAHP had done well, so we decided to market it to local employers. Initially, all 24 physicians in the area were members of FAHP, 10 of whom were also practicing in FGP, but when we decided to market FAHP to companies on a prepayment basis, all but two of the physicians outside of FGP got out of it. They weren't willing to accept a change in philosophy from fee-for-service to prepayment. Before this, the plan was a means of getting paid for services rendered to the poor; people who couldn't otherwise pay. But the physicians weren't willing to be at risk for people who would pay anyway through the fee-for-service system.

FAHP had four full-time social workers who reported to a social worker with a Bachelor of Social Work degree. They worked with three social workers from the Community Action Program, and ran a home insulation program, a food stamp distribution program, and a parenting program. Mr. Johnson saw them as more than just providers, however:

In general, they do a lot of outreach for FHA. People don't understand how to use the system. They won't use the facilities until they're at death's door. Attitudes are slowly changing as new people move into the area who are used to sophisticated medical systems. It takes time for patients to adjust to the less personal setup we have after being treated by an M.D. in a boarded-up back porch in the boondocks. To some patients we are considered the "General Electric" of health care.

Twenty percent of FHA's physician encounters were with prepaid patients from FAHP, which, in Mr. Johnson's view, wasn't enough:

Eventually, I'd like to see 40 to 50 percent of the patients enrolled on a prepaid basis. This would help out on our seasonality problem. In the winter we have heavy usage of the facilities, whereas, in the summer, usage is the lightest. Our costs are fixed, but our fee-for-service revenues fluctuate. If more of our patients were prepaid, we could reduce our cash flow problems.

I don't think there is a conflict of interest between FAHP incentives to encourage physicians to underutilize services and the FGP fee-for-service incentives to increase utilization. The physicians see the same patients over and over again so there is continuity of care. They wouldn't treat the FAHP patients differently from the fee-for-service patients just because of the patients' payment mechanism. The patients receive equal quality of care. I want FAHP and FGP to operate side by side to provide patients with a prepaid alternative to more expensive health care and a traditional fee-for-service mode where it is more appropriate.

Research and Development

R&D had many different projects, which fell into three categories: educational services, community services, and the Early Periodic Screening and Diagnostic Treatment (EPSDT) Program. The division also did some pure research, such as testing blood pressure medicine for drug companies. The projects operated independently with each project director reporting to Mr. Johnson.

R&D supported patient education projects in areas such as blood pressure, diabetes, nutrition, and obesity. The goal was for the division to provide the financial support for these preventative health activities through grant money until such time as they were self sufficient. Mr. Johnson commented:

I can't conceptualize the group without the R&D component. It is a must for serving the needs of the community, for providing expanded services, and for developing alternative delivery systems. For example, FAHP needs more patient education, and eventually we'd like to build some patient education services into the prepaid premium. We also have a pediatrician in FGP who is active in a school health program sponsored by R&D.

Additionally, EPSDT is a federally funded program for Medicaid youngsters. Unlike most of our other R&D programs, the grant pays for some overhead costs, so it eases up the financial load for R&D. The community services program provides services to employees of local industries. We have tried to keep the full-time coordinator, a half-time secretary, and several part-time nurses. It has become known as the West Central Maine Health Services, and it is financially self-sufficient. I'm considering making it a fourth division. You see, we use R&D as a means to develop programs. If they fail to develop beyond the dependency stage, we disband the program. When they become self-sufficient we try to incorporate them into another division or perhaps set them up as a separate division.

REPORTING RELATIONSHIPS

FGP had an active medical staff, governed by an executive committee that met for lunch on Mondays and Thursdays to discuss problems that affected quality of care and physician well-being. In Mr. Johnson's view:

> Unfortunately, the committee often turns out to be a discussion group, and won't arrive at decisions unless an administrator is present to provide information and act as facilitator. Even so, the physicians must have a voice in the running of the organization and a sense of control over their destiny. The administration meets with them at their beck and call.
>
> Recently we hired Jack Barber as business manager of the group practice. He has an undergraduate degree in History with a Masters in Human Relations and 21 years in the Navy Medical Administration. Until we hired Jack, I spent 75 percent of my time in the day-to-day operation of the group practice; now it's more like 25 percent. In a setting like this, Jack doesn't have line authority. He doesn't run things; he sees that things are run.
>
> In this regard, we adhere to the "every tub on its own bottom" philosophy for each division. So far the triadic structure has worked well. The organizational skeleton is just right. The major weakness in the system is working with the physicians. It's like a college president working with the faculty. Professionals have to have a voice in running the organization.
>
> As executive director, I try to maintain a team with which I have rapport. I need to be kept informed. I do a lot of internal management, but about 50 percent of my job involves politics. For example, I'm beginning to develop a program with the elderly, which means negotiating a contract with Medicaid.

BUDGETARY PROCESS

The budgetary process differed for each division. In R&D each project director submitted a proposed budget to Mr. Johnson showing the expected revenues and expenses for the coming year. He reviewed the budget and then met individually with each project director to firm up the figures. In FAHP, the financial director, Mr. McMahon, and Mr. Johnson developed a budget jointly. In FGP, Mr. Barber and Mr. McMahon developed the budget and then discussed it with Mr. Johnson. In all cases the final figures were examined and approved by a committee of five board members, Mr. Barber, Mr. McMahon, and Mr. Johnson. Mr. Barber commented:

> FGP is our main problem area; it's where we've had a large discrepancy between budgeted and actual, and where we've incurred considerable deficits in the last few years in growing proportions [see Exhibit 2]. Until now, when a nursing supervisor wanted to know if she could buy a piece of equipment, she would just call up Ron and he'd tell her if there was enough money available to make the purchase. Now, we're at the point where we need a more efficient system. Here's how the process works right now:
>
> Our fiscal year runs from July to June, and we start the budgetary process in May, when Ron gives me revenue totals for the year to date. Unfortunately, the time lag for our computer information is from 30 to 45 days, so March is the most up-to-date revenue report available. The report provides us with a summary of actual revenues generated by each practitioner, including the three RN/PAs.
>
> Using the March report, we extrapolate the revenue for the three remaining months of the fiscal year. This then provides us with a baseline figure for each physician. We then make modifications to this expected revenue according to anticipated changes in physician productivity, patient volume increases, and price changes in various categories. We consider each physician separately. For example, one of our family practitioners recently came down with Hodgkins' disease, and an internist had a nervous breakdown. Obviously, the expected productivity of these providers must be modified for the new fiscal year.
>
> Last year, we factored in a 10 percent increase in volume. But what we've actually experienced was a 2 percent decrease. I'd really like to examine the trends for the area. Everybody tells me the population is going up, but some demographic information would be helpful in determining expected volume increases.
>
> If we are planning on a 5 percent charge increase for office visits, then we must adjust the expected revenue for each physician separately. For example, a charge increase in office visits will affect a family practitioner more drastically than it will a general surgeon. We use a detailed Revenue Analysis Report, which indicates the revenue generated by each physician in various charge categories.
>
> We show these figures to each individual physician and he or she tells us whether or not we're on target. For example, an M.D. might say, "I think that's a little high." Then I might remind the physician that he's supposed to be available for office calls, a minimum of 20 hours per week. So, we compromise and adjust the revenue accordingly.

Then we aggregate the revenue for the providers and subtract 10 percent of the total to account for uncollectibles which include bad debts and third-party disallowances. This amount is divided by 12 to get the monthly expected revenue.

PHYSICIAN COMPENSATION

Mr. Barber described the details of the physician compensation system:

Until the current fiscal year, 45 percent of projected revenue was set aside to cover the salaries of the 13 providers, meaning that a predetermined amount was set aside for physician payment regardless of revenue they actually generated. That practice was changed for this fiscal year. As of July, the set-aside is 48 percent of *last year's* revenue. Out of this amount, 40 percent is divided equally among the physicians as a base salary, 15 percent is distributed on the basis of the physician's contribution to the total number of encounters, 40 percent on the basis of his or her contribution to the total dollars generated, and 5 percent is based on seniority.

Changing the payment mechanism was an unpopular move. It took us four months to resolve the issue. There is a difference between managing professionals versus nonprofessionals. For every hour that I spend with a physician, I spend 12 to 15 hours in hard work documenting the case. When I showed them the figures for expenses and revenues, they were more willing to accept it.

At first all of the providers wanted to take a $2,000 pay cut. However, Paul and I just wouldn't accept this, as it wouldn't have provided a long-lasting solution, and then we would have been on the defensive. So, we provided several different formula options to the physicians to consider.

Fortunately, there was an economically minded M.D. with a high regard for the dollar who realized what was happening. He pointed out that the higher generators were bringing in a higher percentage of what was put on the books. Essentially, they were subsidizing the low generators. Under his influence, the physicians adopted the present payment mechanism.

It was rough, though, because for some of them it meant a salary cut. Some were so overpaid that it was a shock. There was a lot of turmoil. One of the physicians decided to leave, as she thought she could do better by herself.

The PA/NP salaries, as well as coverage of administrative and overhead costs, came out of the 52 percent remaining after physician compensation. The PA/NPs were each assigned to a preceptor, and Mr. Barber kept track of each one's encounters and generations separately, just as he did for the physicians. Bob Underwood, for example, worked fairly independently in Family Practice and saw many of his own patients. Maria Hennesy worked in Internal Medicine and was primarily a physician extender. She helped the physician with new patients, did initial screenings, preoperative and postoperative visits, and also visited the nursing home patients. Pat Nurse was a nurse practitioner who worked with the general surgeon doing preop and postop work. She also worked with cancer patients and gave lectures to females on breast cancer. She was popular with teenage girls for physicals and family planning services. Mr. Barber pointed out that this created a problem for him:

I guess she's straightforward, but she charges lower rates than expected. I don't know if it is right or wrong, but it causes me a problem. If the PA/NPs don't generate as much as their salary, we lose money. I spoke to a physician who worked with one of the NPs about the low generation and he said, "She's worth her weight in gold. If you get rid of my NP, you'll get rid of me." But, he isn't willing to pay her out of his salary, or even out of the physician's pot. So, I compromised in this area for now.

The remainder of the expenses were budgeted by using the previous year's actual amounts and giving each section (Medical, Dental, Optometry, Pharmacy, Laboratory, X-ray, Medical Records, Facilities, and Administration) some target amounts.

FHA's overhead costs were allocated to each division somewhat arbitrarily. For example, last year, FGP was assigned 50 percent of all facility and administrative costs. Recently, Mr. Barber had gone through the Medical Arts Building floor plan and had calculated some figures of exclusive use areas for FGP, FAHP, R&D, and EPSDT. He figured out the exclusive and common use areas for the Surgical, Internal Medicine, Family Practice, Dental, and Optometry sections, as well as for individual physicians so that he would be better able to allocate costs on a square-foot basis.

Performance Review

Mr. Barber also had developed a monthly report on revenue generation, which he gave to each provider. It showed total office charges for each physician for the month, the average price charged

per patient, the actual number of hours spent, and the average number of patients seen per hour. He compared these figures with what was possible, and showed the physician the difference between his or her potential and actual earnings for the month (see Exhibit 3). He commented:

> This has really helped out. When I first started giving the physicians this report in November, I would sit down and discuss the figures with them individually. Now they know how to use them, and I just send out the reports
>
> In general, the physicians have responded well. In fact, a few have come to my office for suggestions on ways to improve generation. One physician in particular has been very receptive to my suggestions. He was taking several unnecessary breaks during his daily schedule. When the breaks were cut out, his productivity increased drastically.

The physicians also had their own quality of care report, which did not involve Mr. Barber. At the end of each month, a patient's name was randomly picked from each of the doctor's schedules and the chart was pulled. Each doctor was assigned a chart (other than his or her own) to review. Upon completion of review, the audit was sent to the provider for his or her perusal. If there were any discrepancies, the auditor and the provider might get together to discuss them. Eventually all of the audit forms were analyzed by one person (a physician) and any problems or trends were brought up at the monthly medical staff meeting.

Assignment:

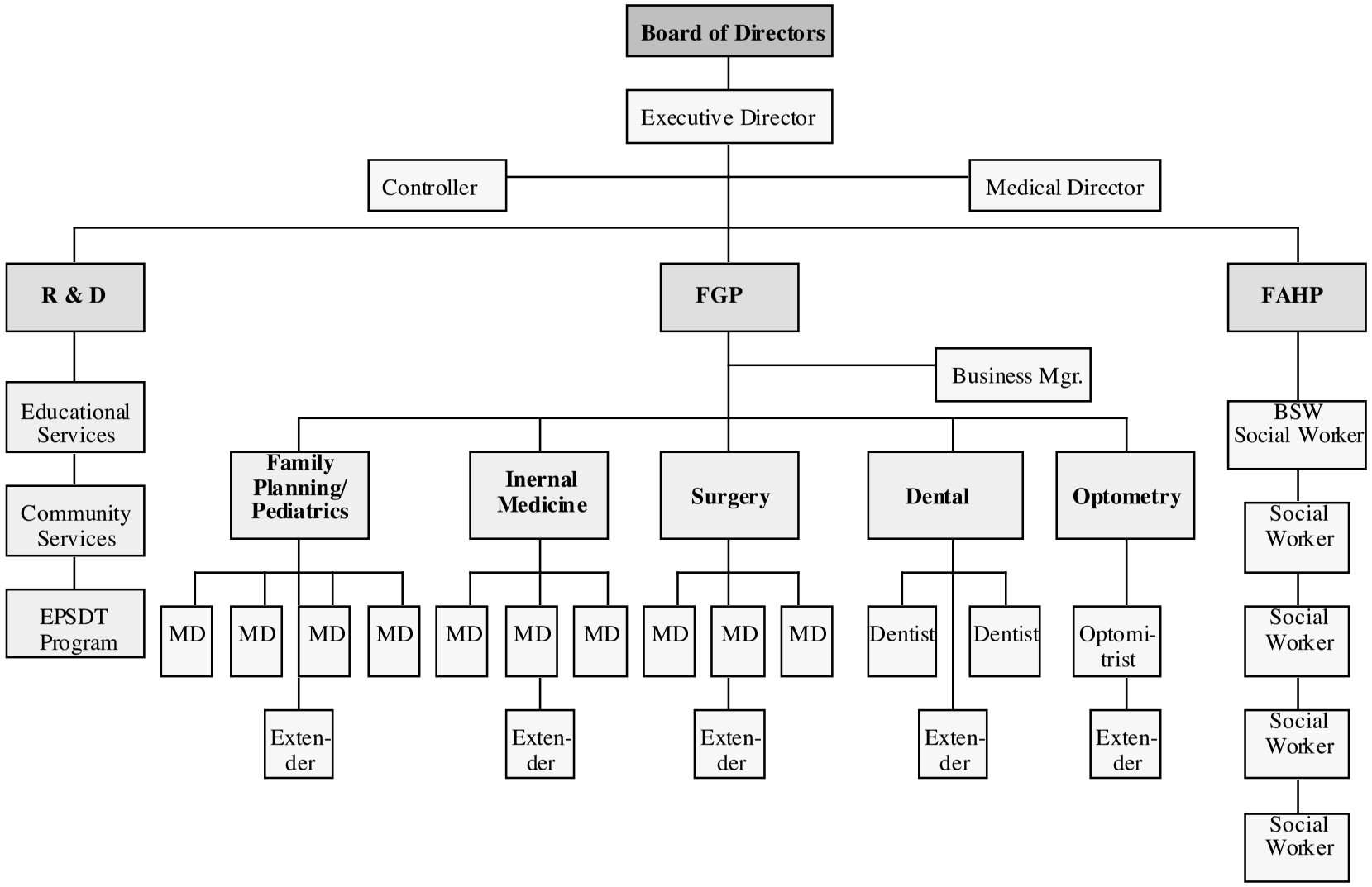
1. What is the strategy of FHA? Be explicit, focusing on programs, markets, personnel policies, and financing mechanisms in particular.

2. Using the organizational structure in Exhibit 1, assess what kinds of responsibility centers have been established at FHA. Are they appropriate according to the criteria for the design of responsibility centers? Why or why not?

3. What is your assessment of the management control process at FHA? How, if at all, would you change it?

4. What should Mr. Johnson do?

FRANKLIN HEALTH ASSOCIATES (A)
Exhibit 1. Organizational Structure



FRANKLIN HEALTH ASSOCIATES (A)
Exhibit 2. Statement of Operations and Comparisons for Franklin Group Practice

	Last Year Month May	*This Year Month May*	*Last Year YTD Through May*	*This Year YTD Through May*	*This Year Prorated Budget*
Generation:					
Medical	$ 219,882	$ 201,588	$ 2,115,078	$ 2,314,468	$ 2,887,634
Dental	29,022	37,370	280,862	327,388	390,272
Optometry	20,370	29,968	245,886	284,122	350,984
Pharmacy	6,436	5,556	66,014	71,898	86,828
Laboratory	22,862	24,084	205,016	234,792	269,612
X-ray	16,664	14,088	170,218	161,292	210,630
Total	$ 315,236	$ 312,654	$ 3,083,074	$ 3,393,960	$ 4,195,960
Grants	5,646	4,078	68,598	49,862	60,000
Other income	(58)	(16)	27,206	2,128	-
Total operating support	$ 320,824	$ 316,716	$ 3,178,878	$ 3,445,950	$ 4,255,960
Less uncollectibles:					
Provision for bad debts	$ 8,862	$ 8,804	$ 87,326	$ 95,928	-
Cash discount	2,946	2,734	26,266	31,004	-
Courtesy and employee discount	390	428	26,002	5,092	-
Disallowed charges	19,770	25,756	208,250	262,972	-
Total uncollectibles	$ 31,968	$ 37,722	$ 347,844	$ 394,996	$ 425,596
Total operating revenue	$ 288,856	$ 278,994	$ 2,831,034	$ 3,050,954	$ 3,830,364
Operating expenses:					
Medical	$ 150,448	$ 133,932	$ 1,517,492	$ 1,674,976	$ 2,044,504
Dental	17,502	19,372	203,688	234,268	267,518
Optometry	23,706	30,682	210,982	249,942	243,522
Pharmacy	5,468	6,110	61,412	73,716	76,000
Laboratory	9,020	8,594	99,832	113,008	121,200
X-ray	7,748	10,706	107,986	112,164	129,600
Medical records	3,112	3,470	37,784	38,098	43,400
Facilities	23,774	22,700	265,646	263,024	313,120
Administration	35,800	43,168	397,810	470,502	580,500
Total operating expense	$ 276,578	$ 278,734	$ 2,902,632	$ 3,229,698	$ 3,819,364
Interest	2,000	1,492	15,186	11,146	8,000
Total operating expense including interes	$ 278,578	$ 280,226	$ 2,917,818	$ 3,240,844	$ 3,827,364
Excess of revenue over expenses (expenses over revenue)	$ 10,278	$ (1,232)	$ (86,784)	$ (189,890)	$ 3,000

* The fiscal year was from July-June.

FRANKLIN HEALTH ASSOCIATES (A)
Exhibit 3. Sample Physician's Report

Dr. Bitterauf May

16 hrs/wk x 4 pts/hr = 64 pts/wk

No. of patients	No. of hours	Generation
208	44	4.7 pt/hr
$36.70	$173.49	$7,634

64 pt/wk ÷ 4.5 days/wk = 14.2 pt/day
14.2 pt/day x 16 provider days = 227 pt/mo (max)
227 pt/mo x .80 = 182
182 x $40.00 = $7,280

$7,634 - $7,280 = $354