

Metro District Health Partners: Issues in patient-centric health-marketing planning

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ABSTRACT

Anticipating the passage of the Patient Protection and Affordable Care Act of 2012 (PPACA), healthcare providers around the country were preparing for a dramatically new health care environment, one with increased responsibilities for a broad range of health care services, including broad-based community health. This case presents a scenario associated with the evolution of one administrator's career path beginning with his limited perspective of marketing planning focused primarily on profit maximization and culminating with his facing several issues associated with implementing a patient-centric, marketing focus throughout his healthcare system.

Keywords: health-care marketing; patient-centric planning; Medicaid health homes; marketing research; services marketing

Note: This case describes the actual experiences of one urban-based health partnership and its administrative leadership during the unveiling of "Obama-care" in early 2012. It was developed strictly for instructional purposes related to patient-centered health care planning as it might occur in the post-PPACA era. All statements, names, numbers, dates, policies referenced herein have been camouflaged and should not be construed as factual.

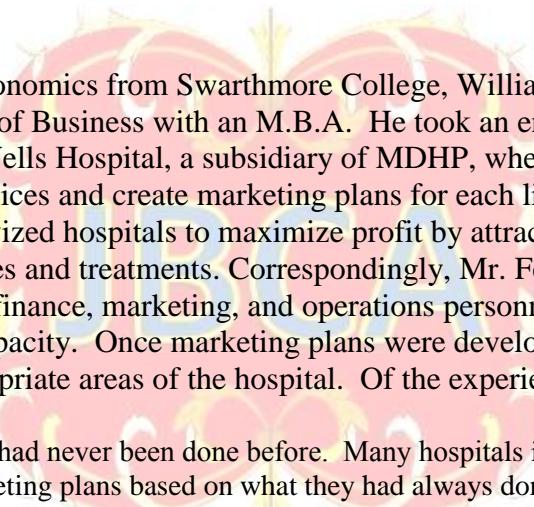
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INTRODUCTION

Sweat streamed down William Ferrum's face as he paced nervously in his office. The entire health care industry was in flux and he was not sure how his hospital system would fare in the brave new world. With the passage of the Patient Protection and Affordable Care Act (PPACA), healthcare providers around the country were preparing for a dramatically new environment, one with increased responsibilities for a broad range of services, including community health. As Executive Vice President of Marketing at Metropolitan District Health Partners (MDHP), Mr. Ferrum was focusing all his energy on guiding his organization through these turbulent times which were destined to change the world of healthcare forever. After months of work, MDHP had successfully been designated an exclusive Medicaid Health Home¹ with the responsibility to manage all patients with co-morbid, chronic conditions in the region. Planning for the significant changes to come, Mr. Ferrum had already commissioned an internal steering committee to make recommendations regarding the PPACA. As he straightened his bowtie, he pondered the monumental challenges that stood in front of him.

BACKGROUND

After earning his B.S. in economics from Swarthmore College, William Ferrum graduated from the Yale University School of Business with an M.B.A. He took an entry-level position in the Marketing Department at Wells Hospital, a subsidiary of MDHP, where his first assignment was to identify high-margin services and create marketing plans for each line. Fee-for-service payments generally incentivized hospitals to maximize profit by attracting patients who required high margin medical services and treatments. Correspondingly, Mr. Ferrum developed cross-functional teams involving finance, marketing, and operations personnel to identify Well's high-margin lines with excess capacity. Once marketing plans were developed and approved, they were rolled-out to the appropriate areas of the hospital. Of the experience Mr. Ferrum noted,


“What we were doing had never been done before. Many hospitals in our area were simply designing marketing plans based on what they had always done; there was no attention to analyzing the market and developing a specific plan to increase business where there was high-margin capacity. The results of the survey were clear; our highest margins were in cardiac surgery and obstetrics. As a result, we commissioned a market segmentation analysis to find out everything we could about these people, where they shopped, what they watched, even what they ate. It became our priority to connect our

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¹ A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

(http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/)

marketing campaign in the most effective way to specific populations. We used behavioral psychologists and ethnographers to help develop messages that we tested in our focus groups. As a result, we found that people wanted to know who their doctors were, more about their credentials, and feel confident they could trust their care. Our marketing campaign was simple; we showcased the best and brightest care providers we had in the high margin service lines to the people most likely to use their service.”

The new pilot marketing program proved very successful and the teams’ focus on patient behaviors and service utilization became contagious. One team member was actually overheard commenting, “This was a whole new world for our organization. In the accounting department we only thought of our patients as numbers, we didn’t realize that they were people with habits that we could track and influence”. The results were astounding and Wells experienced a record increase in patient volume and revenues. Still, Mr. Ferrum was not satisfied.

“There is something missing. Our competitors are mimicking our messages and we’ve started to see a change in the way people think of us. We know that our word was out there and we were established, but we need other ways to differentiate our organization.”

A NEW ERA

While Mr. Ferrum was researching and studying the best ways to attract high-margin patients and further differentiate Wells Hospital, he was promoted to Executive Vice President of Marketing and took over responsibilities for all MDHP marketing planning. In his new position he continued to focus heavily on the challenges of finding the best way to differentiate the entire system.

Shortly after his promotion, however, disaster struck. His youngest daughter, Madeline, was severely injured in a car accident and he spent several days in the Pediatric Intensive Care Unit alongside her. Unwilling to leave her side, he managed all his MDHP duties from a “make-shift” office just outside the PICU, where he got to witness the delivery of the variety of patient services from the patient’s perspective. It was an enlightening and complex experience he had not previously fully recognized. As his daughter recovered, Mr. Ferrum’s attitude began to change and his entire approach to marketing planning for MDHP transformed.

“There is nothing like having a child in the hospital facing intensive care. It changes your entire outlook. The things that made our time better were the people and their patient-centered attitudes and sensitivities toward our special concerns. There were so many nurses, helping hands, and friendly people. Each person clearly worked hard to make our experience a little more bearable. One day as I watched them take care of Madeline I knew our people needed to be front-and-center in any new marketing plan. The moment she is fully recovered I will return to my full time office and begin drafting new marketing and advertising campaigns.”

That’s exactly what he did. Upon his return, his first decision was to commit the maximum available resources to support all front-line caregivers (nurses, technicians, therapists, etc.), and to work to train them how to respond when problems arose. He wanted to ensure they would be fully equipped to provide the best service possible and also empowered to respond immediately to any front-line problems. He knew from experience the often quoted truism about the “moment of truth” (any time a patient comes into contact with a caregiver), that service

failures are inevitable. From his daughter's experience, he now realized that's where the greatest number of service failures were likely to occur and where timely service recovery efforts were essential. In addition, workflows were re-signed and simplified and all caregivers were expected to prioritize the time they actively spent with patients and their families.

The new promotion campaign thus changed from that which he had previously created for Wells Hospital. Advertising focused on heart-warming recovery stories of children like Madeline and illustrated the close personal experiences and special care given by providers at all 22 MDHP primary care sites. The results were immediate and dramatic across all the system's facilities. The hospital quickly grew to capacity and increased its market penetration by 20% under the new campaign. Most of the system's high profit service lines were operating near capacity, resulting in the achievement of its greatest profits in the system's history.

Continuing his marketing planning, Mr. Ferrum sought to adopt best practices from other industries and he benchmarked many competitor health care systems across the country. As he had done before, he commissioned a cross-functional team to develop and carefully refine target markets, to seek out best practices, develop adoption plans, and continue working through all phases of implementation.

A highlight in one team's report that caught Mr. Ferrum's attention and quickly became the focus of activity throughout the hospital - the unusually high cost of Medicaid patients with chronic conditions. As he sought to address this Medicaid concern, a new and unique opportunity presented itself to the healthcare industry. Passage of the Patient Protection and Affordable Care Act of 2012 (PPACA) brought with it new opportunities never before available. The next challenge was the need to decipher various provisions of the Act and identify the best opportunities for MDHP.

PPACA HEALTH REFORMS

Section 2703 of the PPACA provided an optional Medicaid State Plan benefit permitting states to establish Health Homes to coordinate care for Medicaid enrollees with chronic conditions (Health Homes and Primary and Behavioral Health Care Integration, 2011). The MDHP steering committee responsible for handling all PPACA-related mandates, was charged with the task of evaluating and recommending whether to make application to become a Medicaid Health Home (MHH). Within weeks, a positive recommendation from the committee was delivered to Mr. Ferrum and shortly thereafter, MDHP's application was submitted and approved by the state.

Now designated as the exclusive Medicaid Health Home in the region, MDHP assumed responsibility for managing healthcare for all patients with co-morbid chronic conditions. It would have to coordinate care with the many potential providers involved in the various aspects of healthcare delivery and utilize their marketing resources to encourage healthy living and early detection, and to increase utilization of preventative care. Care would now have to be coordinated for patients being serviced by multiple caregivers no longer under only one roof and where some were actually part of other, independent social services groups, like Catholic Charities. Among other things, Mr. Ferrum knew he needed to find ways to share information between MDHP healthcare service providers and several other social services providers. Trying to manage this new interface is where the greatest complications associated with marketing planning and delivering patient-centric services were going to experienced.

CREATING MEDICAID HEALTH HOMES

Although it had been authorized to develop Medicaid Health Homes via their 22 primary care regionally-located sites, the MDHP system was not immediately prepared to launch full scale operations. Colleagues closest to Mr. Ferrum knew of his favorite cliché, “Marketing follows operations,” and understood what he actually meant was not at all what it sounded like. While he always placed the top-priority on trying to understand and focus on the patient’s perspective when developing marketing plans, he referred to it in a way to help his managers also understood the priority of operations in the successful delivery of care. Essentially, as he saw things, unless operations were able to deliver the right service, at the right time, to the right patient, service delivery was destined to fail no matter the marketers’ or frontline caregivers’ sensitivity to patient’s needs. In the case of building Medicaid Health Homes, he also knew that MDHP’s caregivers were the lynchpin connecting all future patients to the system. His next step therefore was to determine what caregivers needed operationally to implement the MHH and ensure that his staff had the tools and training necessary to practice the quality of care consistently emphasized in all of MDHP’s external promotions.

Care management had generally been fragmented at MDHP even with Ferrum’s latest efforts to deliver services as efficiently as possible. As a result, not only were there precious few case managers working on the in-hospital side, but previous process improvement projects had left out-patient clinics operating different care models. Because of this, communication linkages between caregivers were often incomplete. Unfortunately, daily care-team huddles, a practice used by case managers to communicate the plan of care for the patients arriving at the clinic for the day, had been discontinued at MDHP as caregivers became busier with the increased patient loads resulting from Mr. Ferrum’s previous initiatives. Face-to-face communications among case managers, site nurses, and physicians were becoming less frequent as orders were more often being e-mailed rather than personally delivered. In addition, the outpatient electronic medical record system used by the primary-care physicians and caregivers did not interface with that of the regional health network, so communication with community support services was relegated to outdated methods that took time away from patient care (i.e. voice messaging and faxing).

The latest team formed by Mr. Ferrum had the responsibility of looking into utilizing an information technology platform to coordinate care throughout the system. They decided that the MHH initiative provided the perfect opportunity to address communication problems in the outpatient setting. Thus, the care coordination team began to work with caregivers at the various clinic sites to research their current practices and determine where improvements could be made. Figure 1 highlights the five steps undertaken by the team that was built around a survey instrument to be administered at each clinic site. The basic logic was that care-givers should be the best source of information needed to help structure operating systems and also provide greater legitimacy to the overall findings. It was also felt that the surveys would help engage both the staff and physicians and facilitate their buy-in with the new initiative.

Five clinic locations with large Medicaid populations and fifteen caregivers from each were sampled. A 10-question survey instrument was developed following considerable staff input and distributed on-line. Respondents were assured the surveys would be handled in strict confidence and they were given two weeks to complete and return the survey. The questions are presented in Figure 2. Despite the apparent enthusiasm, the overall survey response rate was a disappointing 48% overall and not uniform across the five sites. Site #3 produced a 67% response, while site #5 only had a 33% response. Table 3 presents the response rate data per site.

The findings were also surprisingly variable between the sites. The team did find a few themes that seemed to span both location and job function. Respondents reported communicating with patients and the associated primary-care physician on a daily basis at their respective site. Roughly 4 out of 10 respondents stated that they were not receiving valuable information, and they often failed to receive information specifically related to: 1) the level of social support received by the patient, 2) what referrals were made to other community partners and providers, and 3) a listing of all the caregivers who worked with each patient. Not knowing this information made it extremely difficult for caregivers to coordinate care across the continuum of care. In addition, 33% of caregivers also noted that they were unaware of whether or not patients were educated about their disease and how to best manage it.

Another concern highlighted by the survey was the discovery that 36.4% of responding caregivers did not use the care plan created by the physician. This indicated to the care coordination team that there was a very serious breakdown in communications; a breakdown that could result in disjointed and lower quality care and possibly even bigger problems. Lastly, the care coordination team noted a disconnect between the actual duties performed by caregivers and the duties formally defined by their job titles and position descriptions. Although most likely caused by the different care models instituted at various sites, the team wondered if this role ambiguity might be an additional cause of mis- and under-communications?

On the other hand, there were several positive, more reassuring findings. Many respondents approved the idea of electronic care coordination with enthusiasm; 83.3% expressed interest in having a dynamic care document upon which to coordinate patient care and preferred task and care plan updates to be sent directly to their inboxes. There was almost universal interest (91.7%) in having the care plan offer decision support, such as referral recommendations based upon a patient's medical history. The care coordination team also received positive feedback regarding the benefits of conducting group meetings at the start of each day. Half of the respondents noted that they would see a benefit to a team huddle at the start of the day to discuss patients with appointments later in the day. As expected, those caregivers fortunate to work with an efficient electronic system saw the least benefit in attending face-to-face meetings.

After meeting and reviewing these findings with his committee, Mr. Ferrum knew that MDHP would have to consider conducting further research and develop a broader plan to address various caregiver needs. Healthcare was obviously undergoing monumental changes and he expected MDHP to be on any future cutting-edge legislative initiatives. His previous marketing initiatives had been very successful, but he wondered which marketing lessons would best serve MDHP moving forward, especially as they might relate to launching and maintaining a successful Medicaid Health Home model.

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APPENDIX**Figure 1.**

Step 1. Problem: Poor communications and care coordination problems occurring in clinics

Step 2. Objective: Identify causes of poor communications and care coordination problems

Step 3. Population: Clinic staff & physicians at multiple MDHP clinics (all caregivers)

Step 4. Data collection: 10-question survey; Sample 5 clinic sites at random; Sample 15 caregivers at random per site; Utilize an on-line data collection instrument

Step 5. Analysis. Daily communications regularly occurred; 40% caregivers did not receive valuable information; 36% did not use physician-created care plans; 33% unaware of patients' knowledge of health problem(s); 83% favored dynamic care plans and regular team huddles were favored

Figure 2.

1. Name, job title, professional credentials, clinic location
2. What care-giving tasks do you perform on a daily basis?
3. Do you feel there is a clear understanding of your role at your site?
4. What other care-givers do you work most closely with at your site?
5. How are you notified when a patient's care plan is changed?
6. How would you prefer to be notified of task completions by other providers?
7. When would you prefer to have group meetings to discuss specific patient issues?
8. What are the most problematic current communications problems?
9. Would you prefer your own separate "plan of care" form for each patient?
10. What do you see as the most useful features in an electronic care plan?

Table 1.

Site #	1	2	3	4	5	Total
Responses Received	9	6	10	6	5	36
Surveys Sent	15	15	15	15	15	75

END-OF-CASE QUESTIONS

1. What marketing concepts did Mr. Ferrum utilize at Wells Hospital before his promotion to Executive Vice President of Marketing at MDHP? How did these contribute to the success at Wells and ultimately at MDHP that competitors chose to mimic?
2. What system-level changes did Mr. Ferrum make at MDHP as Executive VP of Marketing after his daughter's accident? How did this compare to his previous actions?
3. What is the goal of the Medicaid Health Home? Identify the major marketing challenges to successfully implementing such a large-scale, multi-facility program.
4. What factors likely contributed to the disappointing overall response rate associated with the in-house survey of physicians and staff at each facility? What are the potential implications to Mr. Ferrum and his task force as they contemplate the findings?

TEACHING NOTE

This case is best suited to advanced under-graduate students with an introductory understanding of marketing principles and an interest in healthcare marketing and planning. Each of the discussion questions can be answered directly by referring to specific sections of the case, but students should also be prepared to engage in broader discussions based on knowledge from previous exposure to basic marketing concepts. Students should be encouraged to discuss a wide range of relevant marking concepts when contemplating answers to each question.

1. What marketing principles did Mr. Ferrum utilize at Wells Hospital that lead to his promotion to Executive Vice President of Marketing at MDHP? How did these contribute to the success at Wells and ultimately at MDHP that competitors chose to mimic?

Instructors may use this question to illustrate several concepts, including the roles of market research and market segmentation, and to explore ways each generally contributed to the successes of both hospitals. Instructors should refer to Ferrum's statement where he referenced an in-depth study of patient's behaviors and how he connected the research to his campaigns.

"We commissioned a market segmentation analysis to find out everything we could about these people, where they shopped, what they watched, even what they ate. It became our priority to connect our marketing campaign in the most effective way to the population

To help formulate his marketing strategy, he first used the results from segmentation studies to develop and refine hypotheses related to patient behaviors and how they made health care decisions. He then used focus groups to further elicit qualitative feedback to help in developing specific messaging for different market segments. Usage segmentation, which identifies and capitalizes on the different behavioral correlates of various market segments' actions, would be especially relevant and useful in this context. Patients considering elective surgeries obviously have far different priorities, behaviors, and information sources than those searching for possible life altering medical procedures (e.g. cancer treatments).

Ferrum's primary conclusion from the research was that patients cared foremost about the skill of physicians. Consequently, he decided to highlight only the most highly-credentialed and respected physicians at Wells in the hospital's promotion campaigns. An astute reader will notice that the marketing strategy does not specify which segment of the market was actually being targeted. From all indications in the case, despite the awareness and potential value of segment-specific findings, a one-size-fits-all promotion campaign was created. The underlying lesson presented, as the student reads on, is that the need for marketing information is

continuous, and that even though this research and implementation of a marketing strategy were effective, it was only the first step in the right direction. The idea of a patient-centric marketing plan is better achieved in Mr. Ferrum's second experience as E.V.P. of Marketing, which is the focus of the next question.

2. What system-level changes did Mr. Ferrum make at MDHP as Executive VP of Marketing after his daughter's accident? How did this compare to his previous actions?

Instructors may use this question to illustrate the concepts of empowering employees, aligning operations with organizational goals, and internal marketing and interactive marketing. Students should refer to Ferrum's post-accident actions chronicled in the case:

"Upon his return, his first decision was to commit maximum resources to support front-line caregivers. He wanted to ensure they would be equipped to provide the best service possible and thereby recognize the importance of their empowerment if they were to handle any front-line problems they would inevitably face. Workflows were also simplified and all caregivers were expected to prioritize the time they actively spent with patients and their families."

Following his daughter's accident Mr. Ferrum redirected his organization's focus towards better meeting the needs of MDHP's patients (i.e. customers). Rather than highlighting only the credentials and skills of top performing physicians in their respective specialties (i.e. "the best and highest credentialed...,") he took the additional steps of training and empowering all frontline staff members to manage patient interactions and trouble-shoot any problems on-the-spot. Because customer loyalty was known to be linked to positive interactions with employees (i.e. interactive marketing), Mr. Ferrum also moved to empower physicians and raise expectations of their interactions and involvement directly with patients, both pre- and post-procedure. These actions would also serve to improve their morale and strengthen interactions with patients.

Mr. Ferrum's effort to make operational changes that parallel marketing goals is an important component of marketing planning. The difficult work necessary to fulfill promises to both internal and external customers, such as making operational changes to support the fulfillment of those promises, signals to staff and customers the organizational commitment to improvement and makes it easier to keep them. By making changes to support physicians and to show commitment to improvement, MDHP was implementing an internal marketing focus as part of patient-centered healthcare. The case also provides the opportunity to discuss the role and importance of service recovery. Since occasional service failures are an inevitable result of service delivery, every service organization needs to proactively plan for and manage service recovery. The "service recovery paradox" can be introduced at this point to further emphasize the importance of managing service failures.

3. What is the goal of the Medicaid Health Home? Identify any major challenges to successfully implementing such a program.

Instructors interested in leading a discussion about healthcare policy may use this question and the fundamental marketing principle of needs-focused marketing (i.e. the traditional "marketing concept" or customer-centric marketing) to explore whether or not the MHH concept addresses patient's needs and how regulation can help or hurt their implementation. Students should refer to developments in the case such as "Health Homes to coordinate care for Medicaid enrollees with chronic conditions" and "This would prove more difficult than the changes Mr. Ferrum previously made at Wells Hospital to focus care around patients' needs because care would have to be coordinated for patients who were not under the roof of the hospital and with

caregivers who were part of other social services groups like Catholic Charities.” As the text explains, sharing information and care coordination are the major challenges. Beyond the simple operational difficulties of coordinating care, instructors teaching health care-related courses can broaden the discussion to evaluate public programs like Medicaid and whether or not they are effective at providing healthcare for the poor. Instructors may pose the question “What do customers need from providers to improve their health?” (in the context of customer centeredness) and then evaluate the Health Home requirements (see PPACA in References) to discuss whether Medicaid is actually taking a customer-centric approach to healthcare.

4. What factors likely contributed to the disappointing overall response rate associated with the in-house survey of physicians and staff at each facility?

Instructors may use this question to discuss several principles associated with conducting surveys: confidentiality vs. anonymity; exploratory vs. descriptive research; sampling; on-line surveys vs. alternatives; survey incentives; and validity. Other than an “unexpectedly low response rate,” the case does not explicitly identify other deficiencies in the survey methodology. Nevertheless, several are implied and can be explored with students. Since the response rate was described as “disappointing” and “variable” across the survey sites, one discussion could focus on possible explanations for the low response rate.

It was only administered in-house to staffers and physicians already aware of the importance of the survey, therefore one can assume there were flaws in the methodology that resulted in more than 50% of respondents choosing not to participate. One concern could be the lack of anonymity provided to respondents. To protect themselves from expressing unpopular views contrary to those favored by administrators, employees could either misrepresent their own views or, absent any indicators of administrative preferences, simply choose not to respond. The latter option would be the safest and could explain the variability in rates across clinic sites resulting from differing views and sensitivities held by the local administrators. On-line surveys always present the risk of identifying respondents (IP numbers are unavoidable). In this case, however, individual names were actually required and were probably viewed as too threatening to the majority of respondents.

A discussion related to response rates also provides the opportunity to discuss the potential validity of the findings (or lack thereof) and the supportive role that incentives might have played. The types of incentives would have to be evaluated on their capacity to ensure anonymity. It should be noted that incentives offered following the completion of the survey would not be useful. On the other hand, several types could have been included with the initial delivery of the survey where respondents did not have to self-identify. Examples that could be provided to everyone would include coupons, rewards cards, gift cards, cash, and the promise of charitable contributions. Finally, assuming the sample size chosen for each site was sufficient at the outset, an argument could be made that a 48% overall response rate compares favorably, or even better than, other survey methods that would involve relatively comparable costs. Comparisons between exploratory, descriptive, and experimental research could also be integrated into this discussion.