C A S E 1

The U. S. Health Care System: Thinking Strategically in a Turbulent Environment

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OVERVIEW

This case is actually an "industry note" that provides a snapshot of the current health care system by describing the significant organizational and professional providers and the major purchasers or "payors" for health care services. A background description of the key historical events and their effects on health care services is included as well as a description of the rapidly changing current environment.

Over the past fifty years, health services have been affected by three basic trends: growth in scientific knowledge, growth in the financial resources allocated to health services, and changed relationships among health care providers, payors, and health care consumers. A number of significant events contributed to these trends (Exhibit 1-4 contains an excellent list). As a result of these events, health care grew faster than any other segment of the U. S. economy moving from tenth largest in 1950 to second largest in 1998 (only behind real estate).

Although the health care sector grew dramatically, the growth was uneven. The percent of total expenditures attributable to the hospital sector declined during the past decade. By 1998, the figure stood at 33.3 percent (hospitals had accounted for 40 percent of health services). The downward trend was related to a real decline in inpatient admissions; however, as inpatient utilization of hospitals declined, outpatient utilization increased.

Physician services made up the largest single professional service component of the health services sector. Payments to physicians accounted for 20 percent of total health services expenditures in 1998, not much different than what it was a decade earlier. Nursing home services accounted for 7.6 percent of national health care expenditures in 1998 (a significant increase over 1960 when nursing home care used 3.2 percent of the health care dollar). However, the availability of beds as measured by the ratio of nursing home beds to population 85 and over decreased. In 1976, there were 681 beds per 1,000 residents 85 years of age and older. By 1998, that ratio had decreased to 446.9 beds per 1,000 population 85 and over.

Between 1960 and the mid-1980s, the portion of the domestic health care dollar devoted to products from suppliers such as pharmaceutical companies and other medical suppliers, actually declined. In 1960, drugs and other medical nondurables accounted for 15.8 percent of health care expenditures. By 1985, the proportion decreased to 8.6 percent; in 1990, the proportion of the health services dollar devoted to drug and other medical nondurables was still 8.6 percent; however, by 1998 the proportion was 10.6 percent and projected to continue to increase.

In the past, households paid for most health services through direct out-of-pocket health spending by individuals, premiums paid as employees (or the self-employed paid into the Medicare hospital insurance trust fund), premiums paid by individuals to the

Medicare supplemental medical insurance trust fund; the employer-paid portion of private health insurance premiums; and individual health insurance policies. Employers had assumed the burden of paying the costs of health care, but the burden was becoming too much for many of them – especially small businesses. In addition, the high costs were forcing many breadwinners to "opt out" of buying health care.

Current environmental trends that are affecting health care delivery include:

1. Declining hospital utilization resulting in beds being taken out of service (equivalent to closing sixteen 200-bed community hospitals in every state between 1985 and 2000).
2. Managed care in the private and public sector was increasing. Medicare and Medicaid were rapidly moving enrollees into managed care arrangements throughout much of the decade of the 1990s. Increasing enrollment but decreasing numbers of managed care organizations resulted in fewer MCOs with larger numbers of enrollees in each MCO. Such a trend suggested increasing bargaining power for managed care organizations when they negotiated with providers such as physicians and hospitals. By the end of the decade the trend was less certain.
3. Changes in the physician workforce as the availability of active physicians increased from 190 per 100,000 population in 1980 to 268 per 100,000 in 2000. In addition, other professionals, including nurse practitioners and physicians' assistants, were serving patients needs.

With this overview of the health services sector, students should have a better grasp of the issues facing health care leaders.

KEY ISSUES

A discussion of the strategic issues that will broaden the student's perspective include:

1. Allocation of health care resources in the United States. Will there be significant changes? If so, what are the changes likely to be? How quickly will they take place?
2. Identification of trends. What are the trends that have occurred in health care over time? Which of these trends are likely to continue? Which are likely to change? What assumptions are made that lead to the conclusions reached?
3. Impact of the changing health care environment on payor groups. How are private businesses and government impacted by the changes in resource allocation methods in health care?
4. Impact of health care inflation on various consumer segments. Will employment status continue to determine access to health care? Will the elderly continue to have access (Medicare)? The poor and infirmed (Medicaid)?
5. The competitiveness of the health care system. Why is health care more competitive today than it was just a few decades ago? Has competition been "good" for health care?

6. Effects of vertical and horizontal integration. Do these strategies make health care organizations more competitive, offering higher quality services? Or do they impede competition? What are the effects of reduced competition?
7. The changing nature of health care cost allocations. How have health care expenditures changed in the past? Will hospitals or physicians play the major role in the future?
8. The role of regulation in a competitive health care environment. Should there be restrictions on health care organizations? Should they be totally free to compete?
9. The affect of purchasing cooperatives on competition. Will purchasing co-operatives enable small businesses to compete with larger hospitals or will the large hospitals become larger?

TEACHING OBJECTIVES

1. To provide background information for the analysis of health care cases that helps to "level the playing field" among students.

2. To provide a "snapshot" of the health care system as it exists today in terms of major provider categories, payor categories, users of health care goods and services, and environmental trends.

3. To identify and analyze changes most likely to occur in the health care system over the near term.

4. To understand historical trends in the health care environment and to speculate on the likely future course of these trends.

5. To foster strategic thinking.

SUGGESTIONS FOR EFFECTIVE TEACHING

At the time this Teaching Note was being written, the national policy debate over health care had once again come to the forefront as medical inflation hit double digits. Managed care attempted to better control rapidly escalating health care costs and change the way health care resources were allocated. Managed care did lower costs for a time, but then consumers began to revolt, demanding choices. It must be noted, however, that late in 2001, the World Trade Center tragedy in New York City has focused much of the attention of U. S. citizens on terrorism and the resulting war. The debate over health care cost, access, and quality will return – it is just a matter of when.

There are several ways to use this Industry Note. The first approach is to assign the Note before any other health care cases are analyzed. This approach ensures a common frame of reference for students. It is a method to "level the playing field" for those students who do not have as much background or experience in the health care field. We have found that using the Note in this way greatly enriches class discussions and improves the quality of analysis for all subsequent cases.

Alternatively, the Industry Note may be used as a case study. If this approach is selected, it is useful to orient the students to the advisor or consultant role. Using individuals or small groups, the students should consider whether they would advise a health care organization to expand, contract, or maintain its scope in the industry. In this orientation, the students must explore the issues underlying the use of expansion, contraction, and maintenance strategies. Such strategic alternatives relate to the major industry issues cited in the Key Issues section of this Teaching Note. In addition, students may identify particular market niches for which they see substantial opportunities or threats.

Another alternative approach is to assign students the task of updating specific sections of the Industry Note. The publication process is slow and the health care environment is undergoing rapid change. By the time this book was printed, a number of significant changes probably have already occurred.

QUESTIONS FOR CLASS DISCUSSION

1. What will the health care industry be like five years from now?

Early in the class discussion, we ask the students this question. The best answers have been fairly specific and well structured with a clear rationale for the description. Though the approaches vary widely, students typically examine the industry through market sectors (acute hospital care, physicians services, nursing home care, or rehabilitation services); categories of key health care organizations (for profit and not-for-profit hospital systems, health maintenance organizations, preferred provider organizations, or medical and allied health education); or key industry trends (growth in supply of physician services, reduction in supply of inpatient hospital beds, growth of ambulatory services, consolidation of the managed care market, and so forth).

2. Consider an increasing supply of physicians, a decreasing ratio of people per active physician, and a decreasing demand for some types of specialty physician services. Over the next decade, what impact might this have on other health professions such as nursing, health administration, and public health?

This question requires that the students consider history to some degree. How did the health professions change when the trends cited in the question were the reverse? What happened to nursing, health administration, and other health professions when we had a physician shortage and demand for specialty care was rapidly increasing? How did the way we paid for health care at that time influence the historical picture? How will the changing payment environment influence the future? Cost-based reimbursement in the 1960s, 1970s, and early 1980s allowed providers to differentiate jobs and rapidly expand the workforce. Current trends increasing the use of capitated payments and pre-negotiated fixed fees encourage other types of provider behavior. Induce the students to consider the changing environment for physician's services and what opportunities and threats this creates for other health professions.

3. What are the approaches for conducting external environmental analysis? What are the advantages and disadvantages of each? Choose one approach and apply it to a health care organization in your community.

Environmental analysis attempts to surface the issues that will be important to health care organizations. A number of approaches can be used to scan, monitor, forecast, and assess the health care environment. These approaches are summarized in the table below.

Rather than everyone suggesting the local hospital, encourage students to select from a variety of organizations (a local long-term care facility, a large clinic, the local public health department, an urgent care center) to discuss a response to this question.. Most any of the techniques can be applied. Thus, the rationale that the student provides for why he or she chose that particular technique should enhance the discussion and learning environment.

Technique	Focus	Advantage	Disadvantage
Simple Trend Identification and Extension	Scanning Monitoring Forecasting Assessing	• Simple • Logical • Easy to communicate	• Need a good deal of data in order to extend trend • Limited to existing trends • Does not foster creative thinking
Delphi Technique	Scanning Monitoring Forecasting Assessing	• Use of field experts • Avoids intimidation problems • Eliminates management's biases	• Members are physically dispersed • No direct interaction of participants • May take a long time to complete
Focus Groups	Forecasting Assessing	• Uses experts • Management/expert interaction	• Finding experts • No specific structure for reaching conclusions
Nominal Group Technique	Scanning Monitoring Forecasting Assessing	• Everyone has equal status and power	• Structure may limit creativity
Brainstorming	Forecasting Assessing	• Fosters creativity • Develops many ideas and alternatives	• No process for making decisions • Sometimes gets off track

		• Encourages communication	
Dialectic Inquiry	Forecasting Assessing	• Surfaces many sub-issues and factors • Conclusions are reached on issues	• Does not provide a set of procedures for deciding what is important • Considers only a single issue at a time
Stakeholder Analysis	Scanning Monitoring	• Considers major interdependent groups and individuals • Assumes major needs and wants of outside organizations are taken into account	• Emerging issues generated by other organizations may not be considered • Does not consider the broader issues of the general environment
Critical Success Factor Analysis	Scanning Forecasting Assessing	• Identifies the factors for success • Directly links external factors with objectives and strategies	• Does not consider emerging trends or issues • Does not consider events in the broader general environment
Scenario Writing	Forecasting Assessing	• Portrays alternative futures • Considers inter-related external variables	• Requires generous assumptions • Always a question of what to include
Porter's Structural Analysis	Scanning Monitoring Forecasting Assessing	• Provides a structured analysis • Provides extensive check-list of issues	• Does not consider the broader general environment • May be too structured to foster creative thinking
Diffusion Process	Scanning Monitoring	• Considers a broad range of issues • Emphasizes data collection • Systematic observation and plotting	• Not industry specific • Little assessment

4. Of the strategic issues facing health care organizations today, which ones are likely to receive attention? Which ones should receive attention?

This question presents an opportunity for students to address strategic issue diagnosis (SID) for the health care sector (or it can be limited to a particular type of health care organization in your area where there are many emerging issues – physician practices, long-term care, home care, or acute care). The issues provided under "Key Issues" is a list that we feel will require addressing over the next several years for the health care sector. For many of them, our society has not determined what we should do to ensure access and quality at a cost that every citizen can afford. Have we reached a strategic pressure point on any of these issues? As of the end of 2001, probably not; but, over time, they continue as issues that will have to be addressed. For example, regulation of hospitals through certificates of need (CON), must be studied to determine whether CONs enhance or hinder competition. In some markets CON legislation is used by one institution to make certain that no other institutions in the area are able to offer similar services (limiting competition). Is the result beneficial for consumers?

As the public has to pay for the "war on terrorism," will we also be able to pay for the increasing costs of Medicare and Medicaid (especially given the increasing unemployment and aging population)? The pressures (issue urgency) may force us to look at the issue, but at this time we do not have great capacity (feasibility) to resolve the issue. The private sector and individuals may be called on to bear a greater burden of health care costs (cost shifting increases again).

Businesses may join together in larger groups to purchase insurance "balancing" the power of large insurance carriers or managed care organizations. Legislated community rating could eliminate the practice of insurance carriers charging small employers much higher premiums and leading to "cherry picking" of the healthiest clients.

Managed care has changed the balance of power in health care. For example, physician specialists were more powerful within hospital systems prior to managed care. With the increase in managed care, primary care physicians – operating as the gatekeepers – developed greater power (and incidentally higher incomes). Managed care attempts to keep people healthier through prevention and early treatment. If it really worked, there would be less demand for hospitals and physicians.

Each of the many issues can be looked at and discussed by the students. The perspectives will no doubt be very diverse as our health care system is complex and we have had little success in determining ways to "fix" the system.

C A S E 2

AIDSCAP Nepal

Ven Sriram and Franklyn Manu

OVERVIEW

In late 1996, Ravin Lama, the managing director of Stimulus Adverizers and Joy Pollock resident advisor of the AIDSCAP (AIDS Control and Prevention) project in Nepal, were in the position of having to evaluate the performance of the AIDS awareness and condom promotion multimedia campaign Lama's agency put in place for the AIDSCAP project. The campaign was launched in July 1995 with several objectives in mind: to increase awareness among the target population that sexual transmission was the primary means of HIV infection and AIDS; to increase the perception of individual risk of being infected; and to promote the correct and consistent use of condoms as a protective measure.

The decision was made to focus on the clients of commercial sex workers (CSWs) as the primary target audience for this campaign, and the CSWs themselves as the secondary target, in the Terai/Central region of the country. This focus on CSWs and their clients made sense given the taboos against extra- and pre-marital sex among the general population, particularly for women. As a result, much of this activity occurred with CSWs. The Terai/Central region was selected because it was home to several major transportation routes along which there was increased commercial sexual activity. Concurrent with this promotion campaign, an expanded condom distribution effort was also ongoing in order to ensure accessibility through traditional and non-traditional retail outlets in the target area.

The case presents information on the details of the campaign and details the key findings from a rapid qualitative assessment study that had been conducted in May 1996 to provide some feedback on the effectiveness of the campaign to that point. In addition, data from a 1994 study, prior to the launch of the present campaign, was presented for comparison purposes. The fundamental questions facing Lama and Pollock were: 1) was the promotion program successful thus far; 2) what changes, if any, were necessary; and 3) should a more detailed assessment be carried out prior to launching Phase II: that was to address issues of fear in the general public regarding people with AIDS.

KEY ISSUES

1. How to decide when to initiate behavioral interventions for a population at risk.

2. Making public health judgments from surveys with small sample size.

3. Ability of behavioral interventions to achieve long term and consistent changes in condom use.

4. The impact on public health judgments of a lack of a control group in the 1996 study.

5. The use of a convenience sample in cultures such as Nepal and other data collection issues.

6. How to address issues of fear in a public health behavioral intervention.

TEACHING OBJECTIVES

This case has the following objectives:

1. To expose students to the intricacies of marketing in an unfamiliar environment and culture and the need therefore to use tactics that are not commonly used in developed countries.

2. To introduce students to the complexities of social marketing – particularly an issue that is as sensitive as HIV and AIDS.

3. To give students practice in the use of inadequate market research data – interpreting and making inferences from study results.

4. To allow students the opportunity to evaluate marketing research that has already been done, redesign an improved study, and determine whether the cost/benefit justifies conducting a further study.
5. To give students the exposure to developing a health education campaign.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case is quite versatile in that it can be used in several courses. The case will give students exposure to what is generally an unfamiliar country. It works well in a Social Issues course for obvious reasons – students can usually relate to the issues in the case given the global concern about the spread of HIV and AIDS. It gives students valuable exposure to how communication strategies are being used to combat its spread in a part of the world where it is now becoming a major concern. There is a good deal of information that can be used to develop communication objectives, design a message, and select media. Analysis of the results from Phase I and designing a more detailed evaluation of the campaign thus far could be a useful assignment. Finally, the case can be used in Public Health and Health Care Marketing and Marketing and Public Policy courses.

The case is perhaps best used in class rather than for an exam. The issues and the context are generally better suited to open discussion. If there are any South Asian students in the class, they may be able to offer a very valuable perspective on some of the issues presented in the case. There usually tends to be a lot of debate on the spread of HIV and AIDS in developing countries and how best to contain this spread.

Specific issues, which may be raised with the students either prior to or during the class discussion, are:

1. What has prompted AIDSCAP to initiate this educational campaign?

2. How successful has the campaign been so far?

3. Is the 1996 assessment of the campaign adequate or is a more detailed assessment necessary? If a more thorough assessment is needed, what additional issues should be considered?

4. What would the elements be of an educational campaign to address issues of fear in the general population regarding people living with AIDS?

STRATEGIC ALTERNATIVES

1. Maintenance of Scope – Enhancement.

2. Maintenance of Scope – Status Quo.

QUESTIONS FOR CLASS DISCUSSION

1. Was there a need for AIDSCAP to initiate the Phase I campaign?

The evidence presented in the case points to the need for an immediate response for the government and NGOs such as AIDSCAP to undertake HIV/AIDS awareness and education programs to slow the spread of the disease. Although it was not yet an epidemic, the indications were that communications targeted at behavioral change among the high-risk groups were necessary.

General responses must consider the fact that given the open border with India, Nepal has cause for concern; early control and prevention measures are a must. Several AIDS researchers have suggested that although rates of HIV infection and AIDS have begun to stabilize in the West, they are expected to increase dramatically in developing countries, particularly in Africa and South Asia.

It is a useful exercise to have students conduct a secondary data analysis (e.g., from WHO and UNAIDS) in order to fully grasp the extent of the problem. For instance, data from India indicates that the HIV infection rate among CSWs in Mumbai has increased from 0.5 percent in 1986 to 69 percent in 1995. This is in a city with an estimated 70,000 CSWs and a country with almost 2.5 million CSWs (out of a total population of over 900 million). Many Nepalese work in India and frequently cross the open border to visit family and friends in Nepal. As a result, infected men can infect wives and other women with whom they have sexual contact on their visits home. In addition, many Nepalese women work as CSWs in Delhi, Mumbai, and other major Indian cities. All this means that although the problem is currently manageable in Nepal, its proximity to and close contact with India means that if something is not done to contain it now, the disease will spread from India to Nepal rather rapidly.

Data from Exhibits 2-2 through 2-5 suggest that there is a strong need for the Phase I campaign. Frequency of condom use is low (CSWs report that 44 percent of their clients never use them and 50 percent of clients in the project area report never using them), and 40 percent of CSWs report that clients refuse to use them when requested. Exhibit 2-4 illustrates that the general level of AIDS awareness is high (82 percent of CSWs and 90 percent of the clients had heard of it), however 47 percent of CSWs and 15 percent of their clients in the project area felt that AIDS was not transmitted. Of those who know that it is transmitted, almost half (47 percent) do not know how. Knowledge of the consequences of AIDS and the preventive measures was alarmingly low, particularly among CSWs.

All the evidence suggests that the Phase I campaign, with its focus on increasing the awareness of the means of HIV/AIDS transmission, and promoting the correct and consistent use of condoms, is needed.

2. How successful has the Phase I campaign been so far?

Although not totally identical, the demographic profile of the CSWs and their clients in the 1994 baseline study (Exhibit 2-1) is not too dissimilar from that of the respondents of the 1996 rapid assessment (Exhibit 2-10). For instance, 76 percent of the CSWs in the 1994 sample and 72 percent in the 1996 sample were below 30 years of age. Literacy levels and marital status were comparable between the two samples. The major difference was in whether they had children -- almost 70 percent in the 1994 sample did but only 36 percent in the 1996 sample were mothers. This indicates that there is prima facie evidence that comparisons can be made between the two samples in order to assess the campaign's success.

The instructor may want to point out the small sample size in the 1996 sample (25 CSWs and 25 of their clients responded) and pose the question as to whether this in any way inhibits the ability to draw conclusions from this study. Given that the purpose of the 1996 study was to get a "feel" for whether the campaign was working, the sample size issue may not be as significant as it might be otherwise. (As a side note, the instructor may also wish to point out a common problem with market research, i.e., that comparisons across studies are often difficult because data is categorized differently. For example, the age groupings for CSW clients in the 1994 study are different from that used for CSWs and also from that used for the clients in the 1996 study. This problem frequently occurs in cross-national data comparisons because different countries/organizations use different measurement ranges.)

<u>AIDS Awareness and Risk Perceptions</u>

Among the goals of this campaign were to increase awareness levels that sexual transmission was the primary mode of contracting HIV infection and AIDS and to increase perceptions of individual risk of acquiring HIV/AIDS.

Data from the baseline study (Exhibit 2-4) and the 1996 study (Exhibit 2-12) shows that by 1996, almost all the CSWs and all their clients had heard of AIDS and were aware of it. In addition, knowledge that it could be transmitted and the modes of transmission had gone up dramatically among CSWs and their clients. The reported

recognition of the importance of condoms as a preventive measure against HIV/AIDS transmission had increased from 34 percent to 64 percent for CSWs and from 55 percent to 84 percent for their clients.

This data suggests that the campaign has so far been successful in its first objective – heightening the target audience's awareness of the role of sexual transmission in the spread of HIV/AIDS. In terms of risk perceptions, there was no significant change between 1994 and 1996 in the percentage of both CSWs and their clients who felt that death would be a consequence of contracting AIDS.

Condom Use and Purchase

A comparison of the baseline data (Exhibits 2-2 and 2-3) with the 1996 assessment (Exhibit 2-11) shows that CSWs reported an increase in condom usage by clients, with 76 percent indicating usage at some time. The percentage of clients reported to use condoms all or most of the time went up from 29 percent to 60 percent according to the CSWs. The "usage by the last client" increased from 35 percent to 60 percent. Of the CSWs who used condoms in their last sexual encounter, almost half of them indicate that it was at their initiation. On the other hand, nearly 43 percent of CSWs in the 1994 study provided the condom, whereas only 24 percent in the 1996 study reported providing it.

As for the clients, the data from 1994 (Exhibit 2-3) and 1996 (Exhibit 2-11) indicates a substantial increase in condom usage, from 53 percent to 68 percent. However, the number reporting that they always used a condom declined from almost 42 percent to 28 percent. There was also a large decrease in the percentage of clients who report being the ones to first mention condom use.

This comparison of the 1994 and 1996 data indicates that, on balance, there has been some increase in condom use among both CSWs and their clients. However, there is reason to believe that there is still substantial way to go to reach "consistent" condom use, which was one of the key objectives of the promotion and condom distribution campaign.

Media Exposure

As can be seen from Exhibit 2-13, the exposure to a couple of the messages was generally quite high, with radio and billboards being the media through which both the CSWs and their clients had been exposed to the messages. On the other hand, awareness of the "Dhaale and Dhaal Bahadur" and "Guruji and Anatare" messages was low, possibly because these two messages had only just begun running in the media when the 1996 data was collected.

It is important to keep in mind that the issue of HIV/AIDS transmission in Nepal is somewhat unique given the constant flow of people across the open border with India. Students should realize that any assessment of the campaign's success should include similar assessments on the Indian side of the border. Both in terms of coordinating intervention campaigns and in measuring this campaign's impact, collaboration between Nepalese and Indian authorities is essential.

3. Is the 1996 assessment of the Phase I campaign adequate or is a more detailed assessment necessary? If a more thorough assessment is needed, what additional issues should be considered?

The rapid qualitative assessment conducted in 1996 has provided some very useful information for Lama and Pollock in their evaluation of the current campaign. However, the information it provides is not sufficient to thoroughly assess the effectiveness of the current campaign. A more complete study is necessary and the following are some the issues which need to be considered:

Design Issues

The most obvious concern is that of sample size. Only 25 CSWs and 25 of their clients were interviewed for the 1996 study. A sample more in line with the 1994 baseline study (100 CSWs and 209 of their clients) would be more appropriate and likely to provide more stable results.

A more important consideration is the lack of a control group. Since the 1994 baseline study collected data from both the AIDSCAP program area and from a control area (where none of AIDSCAP's promotional and condom distribution programs were in effect), in order to make strong inferences about the success of the campaign, there is need to collect post-campaign data from the control area as well, something which the 1996 assessment does not do. In the absence of this, while there has been an increase in HIV/AIDS awareness and condom use in the program area, it is difficult to conclude how much of this is due to AIDSCAP's interventions and how much due to general increases in awareness from other sources (e.g., government sponsored informational programs, AIDS education in schools). A quasi-experimental design, as shown below, will therefore be necessary to isolate the effect of AIDSCAP's activities.

Area	Before (1994)	After (1996)	Change
Program	P_1	P_2	$P_2 - P_1$
Control	C_1	C_2	$C_2 - C_1$

With this design, the change in the project area ($P_2 - P_1$) and in the control area ($C_2 - C_1$) can be computed for all the variables of interest and thus the net program effect, if any, can be determined as: $(P_2 - P_1) - (C_2 - C_1)$.

Measurement Issues

The 1996 study is also somewhat weak in that it does not measure all the variables necessary to fully assess the campaign. A more thorough assessment should measure all the issues outlined in the campaign's objectives. These include the following:

- Awareness of not only how HIV/AIDS is transmitted but also how it is NOT transmitted. This is important in order to assess the effectiveness of those messages designed to dispel myths regarding transmission.

- Understanding of the risks of HIV/AIDS transmission during sex with non-commercial partners such as spouses
- Perceptions about risk of acquiring HIV/AIDS
- Knowledge of HIV/AIDS symptoms
- Perceptions of the ease of condom availability
- Knowledge about correct condom use
- Knowledge of condom supply sources
- Perceptions of condom use as a disease prevention tool
- Other information such as frequency of commercial sexual activity and frequency of contact with non-commercial partners. This type of information is important in order to isolate the behavior of "regular" CSWs from the more "casual" ones in order to more accurately target interventions
- Media effectiveness

Data Collection Issues

Students may raise concerns regarding the use of a convenience sample and other issues related to data collection. Good students will recognize that in developing countries such as Nepal, limited access of telephones and poor postal services mean that much of the survey data will have to be collected though personal interviews. Illiteracy, particularly among the population of interest (52 percent among CSWs as per Exhibit 2-10) further limits the use of mail surveys. Lack of availability of data bases on the population, non-existent street numbering system in most of the country, non-availability of maps and other such constraints make random sampling almost impossible especially in the rural areas where much of AIDSCAP's interventions have taken place. Within these limitations, however, good quality research can still be carried out and valuable data collected given the presence of educated and trained market researchers in cities like Kathmandu.

These are examples of some of the issues that need to be more completely measured. The important point is that the data collected should help determine whether the campaign's objectives are being met. Only after an evaluation along the lines suggested here is conducted should any modifications be made to this phase of the campaign otherwise there is a danger of acting prematurely by relying on incomplete data.

4. What would the elements be of a Phase II promotion campaign --- to address issues of fear in the general population regarding people living with AIDS?

The case mentions that Lama had to develop plans to address Phase II of the campaign – to address issues of fear in the general public regarding people with AIDS. This had become an important issue in Nepal because a large number of Nepalese women who were HIV-positive had returned home from brothels in India. The general public was not well informed about HIV and AIDS, their consequences, modes of transmission an so on. There was concern therefore that when these HIV-positive women returned home, there would be fear and hostility among the people in the villages and towns to which they returned. They returned home because they generally would not receive adequate care in India and the belief that because of their social networks in Nepal, they would be better looked after. However, public

attitudes toward AIDS and HIV infected people would act as a major hurdle in receiving this care. Hence, the importance of the Phase II campaign.

The task confronting the students with designing a campaign for Phase II is difficult given the lack of information on the current attitudes of the general population about AIDS/HIV, condom usage, prostitution an so on. However, the author who worked with Lama and Stimulus in Nepal was privy to all the available information and this information simply did not exist. All the available information has been presented in the case. Additionally, the funding organizations felt that the limited money was better spent on the Phase II promotion campaign itself rather than on collecting data on current attitudes and knowledge. To some extent, it was felt that since anecdotal information, media reports, and word-of-mouth, indicated that HIV/AIDS infected CSWs and others were returning to Nepal from India, why not simply educate the general population about it.

From an instructional point of view, either of two approaches can be taken in response to Question 4. One is to argue for market research to collect data on the knowledge and attitudes of the general public regarding HIV/AIDS prior to developing the Phase II campaign. Otherwise, there is a real danger that a Phase II campaign based only on the currently available information may be a waste of resources. Under this approach, students should be asked to develop the methodology to collect this information. The second is to put students in Lama's shoes and ask them to develop the campaign with the present information. Here they can be asked to use Exhibits 2-6, 2-7, and possibly 2-8, to set objectives, a budget, select media, and design the creative approaches. Both these approaches are outlined below.

APPROACH 1 : Collect data to determine current levels of awareness.

The major consideration under this approach is to measure the current levels of awareness among the general population regarding HIV/AIDS and its transmission. It is important to assess attitudes regarding people infected with HIV/AIDS. Because little secondary data on these issues exists in Nepal, primary data will have to be collected.

Sample Population

General public (other than CSWs and their clients) in the AIDSCAP intervention area initially. Given the volume of commercial sex activity along the highways and the Indian border, and the perception that the disease was an outcome of such activity, the general population in this area would be the first to have to deal with HIV/AIDS infected people. Subsequently, data will have to be collected from other parts of the country.

The issues pointed out earlier in response to Question 3 indicate that a convenience sample will have to be used. Infrastructural limitations (limited access to phones, unreliable postal service etc.) mean that personal interviews will have to be conducted by a well-trained field staff. In addition, to in-home interviewing, respondents will have to be intercepted in public areas as well such as shops, restaurants, or movie theaters etc. where people tend to congregate.

Data Needs

- Awareness of HIV/AIDS
- Knowledge of its means of transmission
- Awareness of preventive actions
- Perceptions of risks of infection
- Knowledge of its consequences
- Attitudes toward people infected with HIV/AIDS

Data Collection

Given the sensitive nature of the information needed, great care will have to be taken regarding questionnaire design and administration. In-depth training of the field staff will be necessary. This should include an emphasis on rapport and confidence building as well as creating and maintaining an atmosphere of trust, comfort and privacy. Only after this atmosphere has been created and anonymity ensured are people likely to be forthcoming. Gaining the cooperation, trust and support of locally recognized and respected people such as community and political

leaders, shop and business owners, and elders will enhance the credibility of the survey and therefore the response rates.

Both male and female interviewers should be used because in a traditional society such as Nepal, respondents will be uncomfortable discussing such issues with members of the opposite sex. In addition, husbands and wives should be interviewed separately wherever possible given that most women would respond more candidly if their husbands were not present.

APPROACH 2 : Develop an educational campaign using current data.

The key elements of the educational campaign to address these issues should include a statement of the communication objectives, a definition of the target market, a budget, media choices and creative strategy. The case Exhibits 2-6, 2-7, and 2-8 provide the information necessary to determine a budget and select the media. Exhibits 2-5 and 2-12 provide data that may help determine the effectiveness of different media vehicles in communicating AIDS awareness messages.

The following is one example of a proposed educational campaign for this phase.

Objectives

The campaign's focus initially will be on the early stages of the hierarchy of effects model. Specifically, it will attempt to communicate the following:

- Increase awareness of AIDS
- Increase knowledge about the how HIV/AIDS is and is not transmitted. The idea that if proper precautions are taken, one can live safely with people who are HIV positive or have AIDS

- Increase knowledge that people who are HIV positive can live normally for many years
- Develop attitudes that one should have compassion and support for people with AIDS

Providing information about condom use will not be a major focus of this campaign. Among the general population, condoms are promoted and used as birth control devices. In a conservative society like this, the incidence of pre and extra-marital sex is relatively low and much of it takes place with CSWs. The Phase I campaign would therefore have dealt with this.

Target Audience

The general population will be the target but there will be a geographic focus on the towns and villages along the main transportation routes and along the Indian border given the patterns of movement of people. Initially, the campaign will focus on the near-term because the areas where HIV-positive people return will be the areas where the fear of transmission will be the greatest. Subsequently, the campaign will turn its attention to long-term education and information about the disease.

The Educational Campaign

Students should be asked to formulate their own budget, using the budget for the present campaign (Exhibit 2-8) as their guide. For the present phase, the total media spend was approximately $75,000 for the 1995-97 period. In addition to media, students should budget for production costs of any commercials and other creative material they recommend.

Exhibits 2-6 and 2-7 provide information on print and broadcast media availability and costs. Students will immediately observe that media is quite limited.

TV One government-run TV station covers the entire country with the bulk of the viewership among the urban wealthy. Total reach is approximately 1.5 million in a country with 19 million in population. Very limited number of cable subscribers.

Radio Total listenership of 10 million but the FM coverage is mostly in the Kathmandu valley with a population of just over 1 million.

Newspapers and Magazines Given the high level of illiteracy, mostly reaches the urban educated population.

All this suggests that media not traditionally used in the West will more likely be effective such as cinema advertising, the video vans, street theater, billboards and so on. Little information on audience profiles is available making it quite a challenge to match the media to the desired target audience. However, students will readily see that the media are generally inexpensive. For example, the most expensive 30 second TV spot costs less than $115 and a full page color ad in the highest circulating monthly costs $115.

Based on Exhibit 2-12, radio and billboards were effective in AIDSCAP's target area. Any media plan should emphasize radio (particularly Radio Nepal), billboards, street theater, and video vans for rural reach and TV, FM radio, and print for the urban areas.

Students should provide samples of print ads and TV and radio commercials that they think will effectively communicate the principal goals of the campaign. They should be encouraged to develop a script for the street plays and storyline for a film which would be screened in the video vans and in the movie theaters.

It should be pointed out that international cases often suffer from the problem of inadequate/incomplete data, but that in itself may be an vital lesson to those students used to the luxury of too much information. As it turns out, Lama had neither the information nor the resources to collect the information about the general public's attitudes and in mid-1997 launched the Phase II campaign based almost entirely on the information presented in this case.

EPILOGUE

In late 1996, Lama determined that the rapid qualitative assessment was not enough and decided to conduct a more detailed quantitative assessment. He felt that data from the control area (areas where AIDSCAP's programs were not ongoing) was necessary in order to adequately assess the effectiveness of the current campaign. As a result, 164 CSWs and 231 clients from the project area and 112 CSWs and 157 clients in the control area were interviewed. Based on this information, he concluded that HIV messages had been successfully disseminated and understood by the target populations and that condom use had increased markedly among CSWs in the project area but not in the control area, thereby suggesting that the interventions were effective. However, for the clients, condom use had increased in both areas, possibly due to the greater mobility of clients between areas and their greater exposure to national condom promotion media campaigns. In addition, CSW and client perception of condoms had changed from a method of family planning to disease prevention. However, Lama felt that he needed to continue this phase of the campaign in order to further increase condom use rates in general as well as by clients in sexual contacts with wives and other non-commercial partners.

In mid-1997, Lama began to develop plans for Phase II of the campaign – to address issues of fear in the general population regarding living with HIV-positive people and those with AIDS. No additional research was conducted to assess current attitudes; Lama's campaign was based almost entirely on the information presented in the case.

C A S E 3

Indiana State Department of Health: Managing Strategically

Peter M. Ginter, Linda E. Swayne, and W. Jack Duncan

OVERVIEW

John C. Bailey, MD, was appointed by Indiana Governor Bayh to the Executive Board of the Indiana State Department of Health (ISDH) in 1989. After being appointed Commissioner of ISDH, Dr. Bailey reviewed the organization and its plans. He decided that a major strategic planning effort was required to overcome the bureaucratic inefficiencies and to work effectively in the rapidly changing environment. Joe D. Hunt, the director of the Office of Policy Coordination was given responsibility for development and coordination of the strategic management activities. The strategic planning process was adopted by the department to analyze the situation facing the Indiana State Department of Health. The process involved five task forces totaling more that 100 employees from throughout the organization. The task forces performed situational analysis and developed strategies to provide high quality public health service to the people in the state of Indiana despite a resource constrained, rapidly changing health care environment. Students must examine and understand the results of the situational analysis, their impact on major health policy issues in the State of Indiana, and determine implementation strategies.

KEY ISSUES

1. Strategic management in a rapidly changing health care environment.

2. Instituting strategic management in a decentralized, not-for-profit organization.

3. Achieving strategic focus in an organization with a broad portfolio of services and activities all of which are important.

4. Deciding the nature of public health in light of limited financial and human resources.

5. Methods for thinking strategically and prioritizing public health programs.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Demonstrate the applicability of strategic management in public health organizations.

2. Assume a decision-making role regarding the development of strategies and implementation plans.

3. Understand that there is no "calm" time to plan.

4. Discuss ways that an organization might prioritize programs and reallocate resources using situation analysis as background information.

SUGGESTIONS FOR EFFECTIVE TEACHING

Users of the 3rd edition of this text will recognize much of this material as being from Chapter 14, Creating the Strategic Plan: An Example. This case may be used as an illustrative example of the strategic management process as it happened at the Indiana State Department of Health. The results are those actually produced by the ISDH personnel. The case is an excellent summary of situational analysis and the strategic thinking process.

In teaching this case we usually ask students if they have had any experience in strategic planning. Often students have been involved in strategic planning in an organization in which they have worked or been a member. We ask them to describe the process their organization used to carry out strategic planning and compare it with the process presented in the text. We typically ask the students to comment on the usefulness of the methods presented in the text to stimulate strategic thinking.

In discussing the case, we emphasize that what the health department *should* be doing (its optimal portfolio of programs) is determined by its external environment (community, state, and national issues). What the department *can* do is determined by its strengths and weaknesses. It is the combination of external issues and internal strengths and weaknesses that will determine the appropriate mission, vision, and strategy for the Department (what it *wants* to do). Therefore, it is useful to break the class into external issues and internal issues groups to lead the discussion. After thoroughly discussing the external issues and internal strengths and weakness, the instructor should ask the class, "Where do we go from here?" Some students may indicate that the strategic plan is completed. They may need to be "encouraged" to work though implementation. After discussing how implementation may vary from for-profit to not-for-profit, private and public, large and small organizations, students should come to the conclusion that implementation must be uniquely applied to public health organizations as well. The collection of programs offered is the "product" and when direction and adaptive strategies have been determined the important question, "What is the appropriate portfolio of programs?" must be answered. Ask the students which of the strategic thinking maps works best for determining the appropriate portfolio. Then ask, "Are the methods they used to prioritize their programs appropriate?"

A speaker from the public health department in your state could be invited to listen to the discussion and provide information particular to your state's situation.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of the Indiana State Department of Health's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths

1. Ability to deal with external change.
2. Strong external and internal customer/client orientation.
3. Commitment to a high level of service quality.
4. Highly qualified and resourceful Management Information Systems (MIS) and Office of Communication employees.
5. Ability to write and receive federal grants.

Weaknesses

1. Vision inadequately communicated to employees.
2. Lack of creativity/innovation in management processes.
3. Decreased funding from the state.
4. Financial limitations prevented the Department from keeping up with industry in automation and computerization.
5. Lack of effective communication up and down the organization as well as with external groups.
6. Inadequate physical facilities.

Opportunities

1. The need for greater emphasis on core public health – assurance, policy development, and assessment.
2. Increasing number of health care systems.
3. Increased public and private partnerships.
4. Special population programs (designed to meet specialized needs – substance abuse, education, and so on) have been successful in reducing specific public health problems.
5. Public's demand for emphasis on prevention.

Threats

1. Impact of health care reform.
2. Limited funding for public health.
3. Increasing amount of violence.
4. Increasing need for emphasis on prevention.
5. Access/care for special populations.
6. External technological advancements.
7. Rise in substance abuse among more populations.
8. Home rule of counties make it difficult to coordinate state-wide public health initiatives.

STRATEGIC ALTERNATIVES

1. Enhancement/alliances and joint ventures/analyzer/focus differentiation – cooperation strategies with private health care organizations and counties.

2. Enhancement/quality – improving public health programs.

3. Product development/internal development – in core public health areas.

4. Defender – core public health.

5. Value adding support strategies – building culture, streamlining structure, and upgrading technologies (information systems).

QUESTIONS FOR CLASS DISCUSSION

1. What are the most important environmental factors that Indiana State Department of Health should incorporate into its strategic planning effort?

The external task force identified twelve major stakeholders that were considered central to the department's mission. The students should be encouraged to discuss the nature of these stakeholders, their relationship with ISDH, and how they are related to the mission of the department. Exhibit 3-5 describes the general purpose and nature of the relationship of various stakeholders with ISDH.

In addition to stakeholder analysis, the task force summarized several trends and issues in Exhibit 3-6. Students should be encouraged to discuss and rank the issues/trends according to their importance. The high impact issues/trends should be separated from the others based upon their weights. These high impact issues/trends then can be compared with the significant trends/issues identified by the task force in Exhibit 3-7. The idea behind this exercise is to help students understand that tracking all the issues may be too difficult to incorporate into the decision making process. Once the high significance issues/trends are identified students can discuss the opportunities and threats for these issues as described in Exhibit 3-7.

2. The scenarios that ISDH used in the early 1990s are now somewhat dated. What are some possible health care scenarios for the first decade of the 21st century?

Students often write scenarios heavily influenced by recent events – World Trade Center disaster, passage of patients' bill of rights, declining enrollments in traditional HMOs and so on. They should be encouraged to think about additional factors as well as their long-term impact. The following three scenarios were developed by the Institute for the Future in *Health and Health Care 2010: The Forecast, The Challenge* (San Francisco: Jossey-Bass Publishers, 2000), pp. 10-14.

Scenario One: Stormy Weather

None of the fundamental problems of cost, quality, or access are resolved by 2005. Between 2005 and 2010, managed care fails to deliver reduced costs or push quality resulting in a backlash by consumers and providers. Legislation is enacted to negate the authority of managed care. Medicare cherry-picking by risk insurance plans leaves the sickest patients to be covered by conventional indemnity plans. A few major provider groups emerge; physicians and hospitals fear leaving their group. In a tight labor market, large employers continue to offer health benefits to

employees; smaller employers are less able to pay for the increased costs. Health care spending reaches 19 percent of GDP and 22 percent of the population is uninsured. New technology continues to offer improved, less invasive alternatives and is demanded by baby boomers – a knowledgeable group that expects to participate in their own health care decisions. No social consensus develops to limit end-of-life care. Information technologies require huge investment but lead to disappointing results in terms of cost savings. The public health sector minimally meets its mandated functions. People worry about losing health benefits and most are unhappy with the increased out-of-pocket costs. Medicaid strains state budgets; Medicare strains the federal budget – especially as early boomers begin to access the system in 2010. Health care reform is in the forefront of public policy once again.

Scenario Two: Long and Winding Road

Large employers maintain price pressure on health plans and require greater contribution by employees. The increased out-of-pocket costs cause employees to reduce their use of health care services. Health plans tighten control through closed networks that pressure providers for clinical price controls. Providers attempt to resist the insurance "hassles" with very limited success. The 1998 federal budget bill includes Medicare and Medicaid cost containment as it does each year following. The public health system continues to compete with the private sector on health service delivery. Health care costs reach 16 percent of GDP and 16 percent of the population is uninsured. The system remains tiered with 20 percent in public coverage or uninsured, 60 percent in restrictive managed care, and 20 percent in high-end, indemnity insurance programs. Cost-based reimbursement is curtailed; large integrated providers have not materialized. Physicians tend to practice in small groups (although there are no solo practices). Comprehensive health care reform does not rise to the top of the public policy agenda because the system is managing to "muddle on through . . ."

Scenario Three: Sunny Side of the Street

Competition drives excess capacity from the system and providers and patients work together to improve health. Newly trained physicians have lowered income expectations. Providers with best practices survive; consolidation occurs and excess capacity (especially hospital beds) is eliminated. Prospective payment covers all outpatient services. Clinical information systems improve care processes and outcomes. The electronic patient record becomes a reality. Technology focuses on improved outcomes and reduced costs. Therapy trade-off can be made based on cost-effectiveness. Public health engages in public-private partnerships and will focus on assessment, development of policy, and assurance. Health care costs are 15 percent of GDP, and 10 percent of the population is uninsured. The systems are in place to minimize unnecessary variations in health care practices, operate efficiently, track outcomes to lead to further improvements, and handle the aging of baby boomers. Insurors are rewarded for improving the health of a population and focusing on long-term health care decisions.

3. Discuss the development process of the mission and vision statements of the ISDH. Develop a list of critical success factors for the department and discuss the rationale behind them.

Different components of the mission and vision statements are given in Exhibit 3-10. Students should be encouraged to discuss the process adopted by the task force to develop mission and vision statements for the ISDH. If the students had participated in the process, what would they change about the mission and vision? Certainly the length of each should be discussed.

Students can be asked to develop a list of additional critical success factors based upon the situational analysis performed by the task forces and the new mission and vision statements. This list of critical success factors can be compared with the list developed by the task force and the rationale behind development of each critical success factor can be discussed.

Two years after the strategic plan was completed, the ISDH reviewed its directional strategies. The Executive Staff decided that although the mission was still accurate, it needed to be shortened. A more succinct statement would better communicate what the ISDH was all about to stakeholders and employees alike. The revised mission statement was posted throughout the building and incorporated into many ISDH documents. It was revised as follows:

> The Indiana State Department of Health (ISDH) is dedicated to promoting health and wellness among the people in Indiana through planning, prevention, service, and education. The ISDH serves to help people attain the highest level of health possible. The ISDH is a proactive leader and collaborator in assessment, policy development, and assurance, based on science, innovation, and efficiency.

4. What are the strategic objectives of ISDH? Discuss the different strategic alternatives available to ISDH to fulfill its objectives.

The strategic objectives are developed from critical success factors. For each objective, strategic alternatives are considered to develop appropriate strategies. The students should be encouraged to discuss the priority setting and need/capacity assessment techniques used by the department to decide what strategies will be appropriate for the organization and county departments. Better students will also consider the possible scenarios of health care reform discussed in Exhibit 3-13, and consider developing strategies based upon the possible outcomes of these scenarios. The key idea behind this process is to foster strategic thinking among students.

5. Can the methods used at ISDH work for your state health department?

The strategic management process used at ISDH should work well in most public health organizations. Organizations engaging in strategic planning will have to identify external opportunities and threats, internal strengths and weaknesses, and develop a mission, vision, values, and goals. Further, a strategy must be developed that accounts for the diversity and range of public health programs. Therefore, it

would appear that program evaluation and prioritization would be a good starting point. However, managers (students) must always make a method or approach work for them, not work for the method. When working through a process, if a method or approach is not contributing to greater understanding, then it should be modified to better serve the organization's needs or abandoned in favor of an approach that does contribute to improved effectiveness in reaching a decision.

6. Ask the students to use case data and undertake a Q-sort of ISDH programs.

A Q-sort of ISDH programs might appear as follows:

Q-Sort Results: Scenario Two -- Core Public Health Plus Special Needs

				(55) FHS: Women's Health				
				(47) Lab Support Services				
				(11) Health Planning				
				(22) MCH: Family Planning				
			(44) HFS: Long Term Care	(34) OA: Finance	(54) MCH Pregnancy Risk			
			(46) ACS: Health Inspections	(52) CDP: Injury Control	(10) Management Information			
		(56) MCH Program	(57) Retail Food	(3) MCH: Lead Poisoning	(18) PHS: Birth Problems Registry	(73) MCH: SIDS		
		(69) Consumer Health Lab	(59) Manufactured Food	(5) MCH: Adolescent Health	(43) MCH: Breastfeed Promotion	(24) OSP: Disability Concerns		
		(7) Nutrition/ WIC	(71) SE: Environment Health	(6) Child Special Services	(32) OA: Admin. Services	(29) OPA: Media Relations		
		(63) SE: Residential Sewage	(72) MCH: Healthy Pregnancy	(36) OA: Human Resources	(35) OA: Purchasing	(39) FM: Physical Plant		
	(65) Environmental Health Lab	(58) CS: Meat and Poultry	(2) MCH: Genetic Disease	(45) HFS: Regulatory/ Support	(70) OSP: Rural Health	(23) Policy Coordination	(28) HE: Library	
(51) Communicable Disease	(17) PHS: Vital Records	(61) Wholesale Food	(8) Oral Health Services	(66) SE: Plan Review	(19) Grants Resource Center	(1) MCH: Family Helpline	(13) HP: Financial Disclosurg	(37) FM: Safety Programs
(9) Epi. Resource Center	(67) Disease Control Lab	(64) SE: Vector Control	(21) Local Health Support	(15) PHR: County Assessment	(38) FM: Environmental Services	(25) OSP: Minority Health	(12) HP: Certificate of Need	(42) OA: Consultive Services
(49) HIV Prevention	(48) CTS/STD	(14) Public Health Research	(53) Chronic Disease	(20) Legal Affairs	(41) FM: Asset Service	(27) HE: Film Library	(40) FM: Security	(33) OA: Correspond Center
(62) WFD: Milk	(16) Public Health Statistics	(26) OPA: Health Education	(4) MCH: Prenatal Substance	(68) Indoor Radiologic Health	(50) HIV/ STD Clinical Data	(60) CS: Weights & Measures	(31) OPA: Print Shop	(30) OPA: Photographer
Most Important	**Next Most Important**	**Next Most Important**	**Next Most Important**	**Next Most Important**	**Next Most Important**	**Next Most Important**	**Next Most Important**	**Next Most Important**

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7. Ask the students to perform a needs/capacity assessment.

A typical needs/capacity assessment of ISDH programs might appear as follows:

Need-Capacity Assessment Program Plot

High Capacity/Low Need (Contraction/Maintenance) — **High Capacity/High Need (Expansion)**

Organizational Capacity	1.0	1.25	1.5	1.75	2.0	2.25	2.5	2.75	3.0	3.25	3.5	3.75	4.0
High 4.0													
3.75												7	
3.5							6		72		44 56		
3.25				43			22 73				46		
3.0						54	2 3	47	45,5 361 63	20 62	29 34		49
2.75						66	41 58		71			50	5 48
2.5		12	1	40		8	13 32 57	4,11 23,5 9 64		14,2 6 69 70	67	9 36 17	15
2.25			33		38	42 68	24 35 37	65	19 39	25		16	51
2.0		27		18	60	31			55		52	21	
1.75		28											
1.5		30											10
1.25													
Low 1.0													

Low — **Community Need** — **High**

Low Capacity/Low Need (Contraction) — **Low Capacity/High Need (Maintenance/Contraction)**

8. The Steering Committee of the ISDH adopted approaches to program evaluation to "facilitate strategic thinking within the Agency." What do you think is meant by the term "strategic thinking?"

The steering committee determined that both program priority and needs/capacity assessment would facilitate strategic thinking. These methods are explained in the text. The methods are used to direct decision makers to think about what is really important – to prioritize the Agency's programs based on some consistent assumptions (scenarios).

Strategic management is an attitude – a way of thinking – that is an intellectual process. Strategic management requires a broad base of leadership throughout the organization and asks everyone to think as leaders. In a strategic context this process is called strategic thinking. Vision and a sense of the future are an inherent part of strategic management. Strategic thinkers are constantly reinventing the future – creating windows on the world of tomorrow. Strategic thinkers draw upon the past, understand the present, and can envision a better future.

Strategic thinking, therefore, is an important foundation of strategic management. The rationale underlying strategic thinking is that what was appropriate and worked in the past is not necessarily appropriate or what will work in the future. It is important to understand the external issues (what we should be doing), the internal strengths and weaknesses (what we can do), and mission and vision (what we want to do) and prioritize what the agency will be doing in the future. Limited resources often force priorities (we cannot be everything to everybody). Thus, strategic thinking is about making the hard choices of what programs are most important to the external environment, internal agency capabilities, and mission.

EPILOGUE

Strategic management required a great deal of hard work by ISDH leadership to keep the strategic priorities in front of managers and encourage everyone to think strategically. Although not easy, ISDH now has a better sense of what public health should be in Indiana, has created clear momentum to achieve that vision, and better "owns" its future. The first three years set the direction for the organization, began the process of reshaping public health delivery in Indiana, and created the organizational infrastructure for strategic management. The next three years were spent tying individual jobs and performance appraisals to the strategic plan and creating individual ownership of the strategic plan. Specifically, each job was connected to the vision, mission, strategic goals, values, and strategy, resulting in strategic thinking by each member of the ISDH. They plan to tie employee rewards to contributions to the strategic plan. Discussions at ISDH suggest that the organization feels it can become completely strategically managed within another three years.

The ISDH's Strategic Plan has not been put on the top shelf and ignored. All employees recognize that they have a part to play in ISDH accomplishing its mission and achieving its vision. ISDH's Strategic Plan is a living document that encourages the entire organization to create its future.

During the past several years, the ISDH has systematically shifted personnel and financial resources to the higher priority programs based on the q-sort results. Recall that ISDH's strategic direction (in the statement of strategy) was "an expansion in core public health areas with an emphasis on assessment, policy development, and assurance." There has been a 54 percent increase in funds allocated to core public health.

C A S E 4

Cooper Green Hospital and the Community Care Plan

Alice Adams, Peter M. Ginter, and Linda E. Swayne

OVERVIEW

Dr. Max Michael, CEO of the Jefferson Health System, had the difficult responsibility of balancing cost with care, of rationing procedures with policy, and of juggling personnel with budgets, performance, and demand. Despite the daunting tasks that came with being Chief Executive Officer (CEO) for a county public hospital, he spent two afternoons a week manning the front lines because he believed it was important to know the people whose lives would bear the burden of his policies and decisions. It was there, on the front lines, where he had first encountered the nature of the health care problem and had a vision for its solution.

Community Care Plan (CCP), an innovative approach to delivering health care to the county's indigent population, was started only through Dr. Michael's perseverance, the dedication of small cadre of believers, and a sizeable grant award. The grant was ending and Dr. Michael was faced with deciding the future of CCP. It was his "pet project," his vision for improving health care for the county's population. He had to admit it had met with only limited success. Should he forge ahead with expansion plans to try to achieve a critical mass, hold steady until they worked out their "growing pains," or give up on the plan altogether? He must make this decision in the context of a rapidly changing health care environment, depletion of the grant, and numerous organizational constraints. How would the indigent of Jefferson County receive care?

KEY ISSUES

1. Illustration of the impact of a changing health care environment on a public hospital – health care costs are rising and sources of funding are declining.

2. Flexibility is required to compete, but "safety net" providers often have restrictions limiting their ability to change with a changing environment.

3. Illustration of the complexity of creating a successful primary care network.

4. Consideration of numerous external and internal factors in order to decide the future of the network, and, implicitly, the hospital.

5. Providing health care for an indigent population has unique problems and requires unique solutions.

6. More than a vision is required to develop new, different ways to deliver care.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Understand the impact of a rapidly changing external environment on a public agency.

2. Discuss how a public agency, through visionary leadership, can innovate and change.

3. Understand the importance of organizational structure and culture in implementing strategic plans.

4. Apply strategic management in a chaotic health care environment.

5. Determine a course of action for the Community Care Plan and Cooper Green Hospital.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case is appropriate for graduate courses in health care strategic management, health administration, or public health policy. For health care strategic management students, the instructor may focus on creating a fit with the environment; organizational issues such as structure, culture, and implementation difficulties; and decision making under significant uncertainty. For public health policy courses, the analysis may focus on the development of public health programs, the unique problems and solutions of health care delivery to poor populations, and partnering with other community agencies.

A good beginning question to ask students is, "Why haven't patients such as Martha James not signed up for CCP? The major discussion point will be that they do not know about it but other answers are also important. The patients do not know what it means to have a primary care provider as they have always gone to the ER for care – and although slow, they do receive care. They can't afford to be sick; it costs too much to pay for CCP.

It takes time and money to build awareness for a new service. Can CGH find the funding to gain awareness? Can it be done in time (before the grant runs out)?

Three different groups can be assigned to each of the choices for Dr. Michael: move ahead with expansion plans to achieve critical mass, try to maintain the status quo with the program while culture and structure issues are resolved, or close down the Community Care Plan. Each of the groups can present the benefits of the assigned alternative in turn and after each team has presented, they can point out the problems associated with the other alternatives.

STRATEGIC ALTERNATIVES

1. Maintenance of Scope/enhancement – market entry/alliances with other providers (health department, children's hospital).

2. Value adding support – building the culture, finance, and strategic resources.

3. Market development and penetration – increase number of enrollees.

QUESTIONS FOR CLASS DISCUSSION

1. What are the unique problems associated with delivering health care to an indigent population?

   - Patients face difficult priority choices, and health care often is not a top priority given the need for food, rent, and clothes.
   - Historical reliance on safety-net-providers for health services and lack of knowledge about primary and preventive care.
   - Limited transportation options to reach health care providers.
   - Lack of familiarity with or understanding of concepts such as insurance and managed care.
   - Low literacy levels.
   - Physician extenders, although cost effective, are not valued by the patients as they are not "real" doctors.

2. What is the purpose and structure of the Community Care Plan?

   CCP's purpose is to improve the health status of the community by:

   - Improving access to care,
   - Delivering more appropriate types of care (primary care services rather than ER services),
   - Increasing continuity of care,
   - Reducing the hospital's costs of delivering care to the indigent population, and
   - Attracting more Medicaid, Medicare, and other "revenue" patients.

   CCP's structure consists of:

   - "Hub-and-spoke" network structure
     - Non-physician providers at satellite clinics provide primary care services and serve as "gatekeepers"
     - Specialty and inpatient referrals made to CGH (for adults) or Children's Hospital
   - Prepaid health plan for patients
     - Annual membership fee (payable in installments)
     - $2 co-payments for office visits; variable co-payments for other services and medications, based on income
   - Emphasis on disease prevention and health maintenance

3. What are the factors that point to the need for change by Cooper Green Hospital?

   - Revenue changes
     - Balanced Budget Act and consequent changes in Medicare and Medicaid payment.
     - Challenges associated with the prospective payment system and movement toward capitation.
     - Declining revenue from the Indigent Care Fund.
     - Probability of the Disproportionate Share Hospital program being discontinued.
     - End of funding from Robert Wood Johnson Foundation grant.

   - Competition
     - Because of financial pressures, competitors may more aggressively target Medicare and Medicaid populations as an ongoing source of revenue.
     - Competitors have more adaptive flexibility.
     - Increasing use of network structures among competitors (increasing consolidation).
     - Increasing managed care penetration.
     - Overbedding in the local market (12 area hospitals).
     - Threat of privatization of indigent health care.

   - Shift in focus from inpatient care to outpatient care.
     - Driven by reimbursement changes.
     - Enabled by technological advancements.

   - Customer changes:
     - One-third of Jefferson County's population is uninsured and the number is rising.
     - Health care is perceived as less important thancrime, violence, housing, and drugs.
   - Increase in aging population.
     - More of CGH's target population will be eligible for Medicare benefits.
     - Increase in chronic health conditions, requiring different types of care.

4. What factors constrain the hospital's flexibility -- its ability to adapt to changes in the external environment?

   Its position within Jefferson County government:
   - Not a separate operating authority.
   - Subject to direct governmental oversight.
   - Political concerns affect decision-making.
   - Required to adhere to strict policies and job categories of the County's Personnel Board.
   - Limited options for raising capital.
   - Required to link the hospital's information system with the County system.
   - Increased difficulty concerning "competing" with other health systems and the health department.

Organizational culture and image:

- Mindset of civil service employees.
- Administration has little leverage to overcome resistance to change.
- Difficult to punish or reward employees due to protections of civil service system.
- Lack of customer service orientation.
- Historical reputation as a "charity" or "poor people's" hospital.

5. What are the strengths and weaknesses of Cooper Green Hospital?

Strengths

- Visionary leadership.
- Low staff turnover; some staff are very dedicated.
- Good working relationship with Jefferson County Department of Health.
- Support from the Jefferson County Commission.
- Generally high satisfaction among patients.

Weaknesses

- Image, especially among those who have never used any services at CGH.
- Inadequate information system.
- Age and layout of the facility.
- Long waiting times.
- Limited and unstable funding.
- Lack of strategic flexibility.
- Organizational culture.

6. What are the strengths and weaknesses of the Community Care Plan?

Strengths

- Convenience for patients.
  - Satellite locations reduce transportation problems.
  - Shorter waiting times.
- Effective use of non-physician providers to deliver care.
  - Lower salary costs.
  - Well suited for primary care services.
- Enrollment growth in some clinics.
- CCP's employee culture.
  - High demand for jobs in CCP.
  - Customer service orientation.
  - Eager to innovate to serve patient population.
- Encourages prevention and health maintenance mindset among patients.
  - Improves health.
  - Reduces costs by reducing inappropriate utilization (ER visits, hospitalization).

Weaknesses

- Inadequate market research.
- Marketing implementation.
  - Lack of resources devoted to marketing.

Lack of awareness of CCP.
Reliance on complex written materials for population with low literacy skills.

- Clinics operating below break-even point.
- Lack of coordination and integration between CCP and CGH.
  Information and billing systems.
  Awareness of CCP by hospital employees.
- Lack of administrative resources.
- Lack of its own HMO license.

7. Develop a strategic plan for Cooper Green Hospital and the Community Care Plan.

One class developed the following recommendations. Their suggestions are one approach, obviously, many others are possible.

These recommendations were developed within the following analytical framework:

Looking at Cooper Green Hospital as a whole, what organizational form would best serve the needs of the patient population and ensure the viability of the organization?

- Network model, or
- Hospital model

Based on the choice above, what should the adaptive strategy (expand, contract, or remain stable) for the CCP?

- Network model:
  Stabilize the CCP, or
  Expand the CCP
- Hospital model:
  Contract the CCP, or
  Close the CCP

How should the adaptive strategy be implemented?

What is the appropriate time frame? Should there be a multi-phase plan?
What strategic indicators or performance measures are associated with each phase?
What strategic tasks will need to be accomplished in each phase?

The class recommendations were as follows:

Organizational form

- In order to remain viable in a rapidly changing health care environment and best serve the health care needs of its target populations, CGH must transform itself into a network configuration.
- In order to do this, CCP must become an integral part of the network, rather than a "sideline project." The new network configuration should be based on the CCP model, with some modifications.
- Advantages:
  Improved care
  Improved image
  Ability to compete for revenue patients

- Risks:
  - Financial
    - Capital needed to develop additional clinic sites.
    - Capital needed to develop an information system.
    - Operational expenses for clinical and administrative staff for satellite clinics.
    - Operational expenses for marketing.
  - Political
    - Reassigning and reducing staff.
    - Appearance of competing with other providers, including Jefferson County Health Department.
    - Patient resistance to changes.

- Two phases of implementation
  - Phase I
    - Begin transformation to network.
    - Stabilize the CCP to "shore up" operational and marketing concerns.
  - Phase II
    - Complete transformation to network model.
    - Expand the CCP.

- Phase I (next 12 months)

  Strategic objective:
  - Begin transformation of CGH to a network model.
  - Stabilize growth of CCP and "shore up" operational and marketing problems.

  Strategic indicators:
  - Two clinics at break-even point.
  - Double rate of increase in enrollment in other clinics.

  Strategic tasks:

  - Conduct market research concerning CCP to determine –
    - What are levels of awareness among CGH patients and non-patients?
    - What educational/marketing approaches are best to reach the target population?
    - What factors determine attractiveness to patients and potential patients?
    - What factors detract from consideration of joining?
    - Where should clinics be located?

  - Develop and plan heavy marketing and promotion –
    - Change image and identity from Cooper Green Hospital to Jefferson Health System.
      - Eliminate use of CGH name, logo, signage, letterhead, etc.
      - Eliminate use of CCP name, logo, signage, letterhead, etc.
      - Develop and use one logo for all Jefferson Health System operations
    - Market internally to increase awareness and image among employees
    - Market externally to increase awareness in target population

Determine needs for complete IT integration and solicit proposals
Increase CCP administrative resources
Add staff under Jerome Calhoun to handle workload
Move Jerome Calhoun's office to main administrative suite, for both operational and symbolic reasons
Enlist support of JCC and Personnel Board for changes
Solicit support from physicians and community
Apply for HMO license

All Phase I tasks require significant funding. For example, Dr. Michael estimated that the application process for an HMO would cost between $750,000 and $1 million and take considerable time. Students should have recommendations as to how these costs will be met. For example, a grant might be pursued for the HMO license but there aren't grants available for Marketing. Students in Marketing at UAB might develop Markeitng plans as part of a class project at no cost.

Other hospitals in the area and the health department might be formally pursued as "partners."

- Phase II (12 months to 36 months)

Strategic Objectives:
Complete transformation to network model
Expand CCP (based on research from Phase I)

Strategic Indicators:
Existing clinics should be at break-even point.
20% of patients visits are to be at satellite clinics by 24 months.
50% of patients visits are to be at satellite clinics by 36 months.

Strategic Tasks:
Add target markets:
Working poor (more subsidized care).
Middle class with no insurance (accounts receivable will increase because of extended terms).
Non-poor Medicare (will they come to CGH?).
Insured (will they come to CGH?).
Focus on outreach to local businesses for resources.
Increase number of clinics; complete rollout by 36 months.
Implement IT program.
Promote HMO plan and cutback on FFS/HealthFirst.
Divert services, resources to satellite clinics.
Add/reassign administrative staff, as needed.
Sustain marketing efforts, both internally and externally.
Develop marketing plans for new target markets.

Summary of Recommendations ("take away points")

- Transform CGH into a true network.
- Rename entire organization as Jefferson Health System; eliminate use of other names, logos, signs, letterhead, and so on..
- Make the CCP model an integral part of the network.
- Commit marketing resources essential for success of the network.
- Additional administrative staff needed to focus solely on satellite clinics.
- Develop comprehensive IT system for network model.
- Organizational culture must change :
  - embrace network model and resulting changes in operations,
  - develop more customer-service orientation, and
  - reduce resistance to change; future changes will be needed to adapt to continuing change in environment.