C A S E 9

The New Office of Women's Health: Building Consensus to Establish a Strong Foundation

OVERVIEW

Created by the State of Alabama legislators, the Office of Women's Health was placed within the Alabama Department of Public Health to be an advocate for women's health by establishing appropriate forums, programs, or initiatives designed to educate the public and to identify, coordinate, and establish priorities for programs, services, and resources. Further, the Act appointed a diverse steering committee to guide the activities of the Office. The Steering Committee was made up of representatives from the Medical Association, State Nurses Association, Pharmaceutical Association, the state Business Council, Hospital Association, Dietetic Association, and consumers. Each member of the Steering Committee had strong ideas concerning the appropriate activities for the Office.

To begin the discussion of setting priorities on the activities of the Office of Women's Health, the 2001 edition of *Making the Grade on Women's Heath: A National and State-by-State Report Card* was presented at the first meeting of the Steering Committee. The 33 health status indicators and 32 policy indicators provided a common perspective on the status of women's health across the United States and in Alabama and might be used as a basis to help set priorities for the Office of Women's Health.

The Director of the Office of Women's Health, Patricia Clark, RN, MPH, must find a way for the Steering Committee to reach consensus on the activities of the Office. If Patricia were able to establish a track record, she would have to create focus for the Office and begin some policy or programmatic initiatives. However, she knew there were so many issues and all seemed critical. What should be the focus of the Office?

KEY ISSUES

1. Developing consensus from among a diverse group of decision makers who have very different ideas about what the Office of Women's Health should be doing.
2. Incorporating relevant external environment information into the decision making process.
3. Developing consensus among a limited number of issues drawn from a larger list of possible issues.
4. Limited resources for a very broad mandate outlined in the legislation creating the Office.

TEACHING OBJECTIVES

This teaching note was written by Julia Hughes of Tulane University and Peter M. Ginter and W. Jack Duncan of the University of Alabama at Birmingham. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from the Alabama Department of Public Health.

After analyzing the case, the student should be able to:

1. Recognize that organizations cannot be everything to everyone and that organizational leaders must set priorities and focus.
2. Appreciate that there are many important issues and programs affecting women's health, therefore an effective method for selecting priorities must be developed.
3. Discuss how developing a single criterion for prioritization can be difficult when the issues and the decision makers are quite diverse.
4. Identify the advantages of a structured approach to help decision makers reach consensus on organizational priorities.
5. Use appropriate tools (Needs/Capacities Assessment and Program Evaluation) to reach consensus.

TARGET AUDIENCE

This case is appropriate for upper-level undergraduate or graduate courses in Health Administration where management or strategic decision making in a not-for-profit arena is discussed.

SUGGESTIONS FOR EFFECTIVE TEACHING

Typically when students initially "look over" this case it appears to be rather straightforward. However, a closer examination of the case exhibits suggests that there are a considerable number of potential issues and competing priorities. Developing priorities among a number of very important issues in an environment of limited financial and time resources is a common problem for people in leadership positions. In addition, a diverse voluntary board (Steering Committee) that must reach consensus compounds the problem. Members of the steering committee approached the issues differently based on their education and the stakeholder group they were representing.

In teaching the case, we have found several approaches work well – two approaches for students analyzing the case individually and another approach for group role playing. When the instructor prefers that the case be addressed individually, students may be asked to play the role of the facilitator mentioned in the minutes of the inaugural meeting of the Office of Women's Health. The other approach is to simply ask the student to set priorities for the Office and justify them. The facilitator role requires using a plan or process for the Steering Committee to reach consensus (an approach for focusing the efforts of the Office). Because the second individual approach asks students to actually set priorities, they will have to determine a methodology before they can set priorities. They should be asked to justify the methodology they used.

For the group role playing, we have found that the best approach is to distribute the case and assign students to roles including Patricia and the steering committee members (representatives from the Medical Association, State Nurses Association, Pharmaceutical Association, the Business Council, Hospital Association, Dietetic Association, and consumers). A facilitator role may also be assigned. We then schedule a "round-table" discussion asking the participants to represent their disciplines, discuss the issues, and try to reach consensus.

Typically, the round-table discussion is not very focused and participants tend to use their own criteria to decide what issues are most important. If the students do not recognize that they need some type of structured thinking, the instructor can interrupt the discussion and prompt them until they determine that needs/capacity or program priority setting through Q-sorting helps focus participants. We have used "program evaluation" to provide the necessary structure.

QUESTIONS FOR CLASS DISCUSSION

1. How can Patricia Clark achieve success for the Office of Women's Health?

The steering committee is composed of volunteers, but they are volunteers who are passionate about improving the health status of women in Alabama (which has one of the lowest, if not the lowest, women's health status factors in the country). There is no funding to accompany the legislation that set up the Steering Committee, although the legislature gave the Steering Committee the power to raise funds (which is unusual for a government agency).

Patricia knew she needed to get things in place quickly so that the group could obtain some results and an early success so that funds could be raised. Using the *Report Card* enabled the group to get started more quickly because they had access to some already collected, relatively objective data, and they did not have to waste time tracking down information (which they found was quite difficult to do). In addition, they did not have to spend what little money they did have to be able to access it. Unfortunately however, there were 33 factors highlighted in the *Report Card* and that simply was too many to attempt to deal with given the volunteer nature of the group and the lack of funding (at least at this point in time). A method was needed to focus the group's efforts.

2. What situational analysis tools are appropriate for the new Office of Women's Health?

Although SWOT, PLC, and the extended form of portfolio analysis may be used to evaluate public health programs, evaluation methods that consider increasing profit, revenue, market share, industry strength, and competitive advantage are generally inappropriate and difficult to use in the not-for-profit sector. Not-for-profits such as state and federally funded institutions (state and county public health departments, state mental health departments, Medicaid agencies, community health centers, and public community hospitals) typically have programs that were initiated to fill a health care need within the community that has not been addressed through the private sector. These "health care gaps" have occurred because of federal or state requirements for coordination and control of community health and because of the large number of individuals without adequate health care insurance or means to pay for services.

Within the context provided by an understanding of the external environment, these not-for-profit institutions must chart a future through a set (portfolio) of programs. Therefore, the fundamental question is, "Does this set of programs effectively and efficiently fulfill our mission and our vision for the future?" Two program evaluation methods that might be used to help

structure the decision making process in the not-for-profit setting are Needs/Capacity Assessment and Program Priority Setting.

3. How does a not-for-profit start the strategic planning process?

The set of programs in not-for-profit organizations such as public health departments essentially are determined by (1) community need and (2) the organization's capacity to deliver the program to that community. For the Office of Women's Health there is a mandate to do something but there is considerable latitude as to what. In this case, funding has not (at least not yet) followed the mandate and for the time being the Health Department will be funding the "mandate." Therefore, in developing a strategy for a public health organization or not-for-profit organization serving the community, community needs must be assessed, as well as the organization's ability (capacity) to address the needs.

For public or community health, community need is a function of (1) clear community requirements (environmental, sanitation, disease control, and so on) and personal health care (primary care) gaps, (2) the degree to which other institutions (private and public) fill the identified health care gaps, and (3) public/community health objectives. These gaps exist because there are few private or public institutions positioned to fill the need and, typically, there is inadequate or no reimbursement.

Organization capacity is the organization's ability to initiate, maintain, and enhance its programs. Organization capacity is composed of (1) funding to support programs, (2) organizational resources and skills, and (3) the program's fit with the mission and vision of the organization. Availability of funding is an important part of organization capacity. The Office of Women's Health, although mandated by the State of Alabama, has the "support" of the Alabama State Department of Health, but no specific funding at this time. The legislation did recognize the need for resources and included in the law the opportunity to raise funds for the Office of Women's Health, something that was not typically allowed for government mandated programs.

For the Office of Women's Health, community need was the most important factor to consider in setting priorities as there were few internal resources and skills available at the time. Fund raising activities would need to be tailored toward the Office's priorities. Because of limited financial resources, the Office will be able to address only a very limited number of these needs. Identifying the most important Women's health needs that are not being addressed by other organizations is important.

4. What set of programs will effectively and efficiently fulfill the mission of the Office of Women's Health and its vision for the future?

Exhibit 1 in this Note presents the alternatives indicated for public organizations as they assess community needs and the organization's capacity to fill the identified needs. Where the community need is assessed as high (significant health care gaps, few or no other institutions addressing the need, and the program is a part of the community's objectives) and the organization's capacity is assessed as high (adequate funding, appropriate skills and resources,

and fit with mission/vision), then the organization should consider entering or expanding the area (upper right-hand quadrant). This is not the situation that the Office of Women's Health faces.

When community needs have been assessed as high but organizational capacity is low, the organization might build organizational capacity to address the need (upper left-hand quadrant). As resources become available, and organization capacity increases, programs in this quadrant will move to the upper left-hand quadrant and more aggressive (expansion) strategies may be adopted. The Office of Women's Health is located in this quadrant and building organizational capacity is essential. How can Patricia make it happen? First, the group has to determine priorities that will improve women's health in the state and be appealing to the philanthropic or business community. Resources cannot be sought until there is something to offer.

One approach for the Office of Women's Health that provides structure to the discussion of priorities for the Office is to have the members of the Steering Committee plot the health status indicators provided by *Making the Grade on Women's Health: A National and State-by-State Report Card* (Exhibit 9/3 in the case). This process requires that the discussants be familiar with the health care gaps, institutions providing these types of services, and health priorities (objectives) of the state. With regard to organizational capacity, most all of the health status indicators will be "within the mission" of the Office, however, required resources and skills may have to be built. Plotting the 33 health status indicators from the *Report Card* on the Needs/Capacity Matrix provides some structure for generating and guiding the discussion. (*Note:* The instructor might want to translate the case to his/her own state to enable the students to better know their own state's objectives, gaps in service, and other organizations filling the needs.)

The second method of discussing priorities involves ranking programs. This process is significant because community needs (both the need itself and the severity of the need) are constantly changing and organizational resources, in terms of funding and organization capacity, are almost always limited. Invariably more programs have higher community need than resources are available. The nature and emphasis on programs is the central part of strategy formulation in many public and not-for-profit organizations. However, a problem in ranking these programs is that typically all of them are viewed as "very important" or "essential." Therefore, it is necessary to develop evaluation methods that further differentiate the programs.

One ranking method that can be used is to list all the programs on a separate paper posted in different areas of the room. Provide three different colors or types of stickers. One color would be for expansion of the indicator to require greater resources in the future, one would be that the indicator was expected to contract in the future, and one for no change or it would maintain the same level of resources in the future. Each member of the committee is then asked to sort the organization's programs into the categories – based on their perceived importance to the organization's mission and vision. The group may agree upon several indicators. Discussions can then be focused on those indicators where there is disagreement. After points have been raised and discussed, the programs can be evaluated again, hopefully leading to greater consensus from the group. A form of this approach may be utilized using the 33 Health Status Indicators provided by *Making the Grade on Women's Health: A National and State-by-State Report Card* (Exhibit 9/3 in the case).

Another ranking method is the Q-sort that provides a more formal approach to differentiate the importance of programs and set priorities. Q-sort is a ranking procedure that forces choices along a continuum in situations where the difference between the choices may be quite small. The program Q-sort evaluation is particularly useful when experts may differ on what makes one choice preferable over another. By ranking the choices using a Q-sort procedure, participants see where there is wide consensus (for whatever reasons used by the experts) and have an opportunity to discuss the choices for which there is disagreement (and, hopefully, reach greater consensus).

Q-sort evaluation helps overcome the problem of ranking all programs as very important by forcing a ranking. Therefore, the Q-sort is a way of rank-ordering objects (programs) and then assigning numerals to subsets of the objects for statistical purposes. Fred N. Kerlinger, in *Foundations of Behavioral Research*, characterized the Q-sort as "a sophisticated way of rank-ordering objects." Q-sort focuses particularly in sorting decks of cards (in this case each card representing a health status indicator) and in the correlations among the responses of different individuals to the Q-sorts. Kerlinger reports good results with as few as 40 items (programs) that have been culled from a larger list, but usually greater statistical stability and reliability results from at least sixty items and not more than 100.[1]

In the Q-sort procedure, each member of the steering committee is asked to sort the organization's programs into categories based on their perceived importance to the organization's mission and vision. To facilitate the task, the programs are printed on small cards that may be arranged or sorted on a table. To force ranking of indicators, members are asked to arrange the indicators into piles from most important to least important. The best approach is that the number of categories be limited to nine and that the number of programs to be assigned to each category be determined in such a manner as to ensure a normal distribution.[2] Therefore, for the Office of Women's Health the 33 health status indicators may be sorted as shown in Exhibit 2 in this Note. Notice that to create a normal distribution (or quasi-normal), 5 percent of the programs are placed in the first pile or group, 7.5 percent in the second group, 12.5 percent in the third, and so on. In this case, there is one program in the first group, three programs in the second group, four in the third, and so on.

Depending on in which group it is placed, each program is assigned a score ranging from 1 to 9 where 1 is for the lowest and 9 is for the highest ranked programs. The score indicates an individual's perception of that program's importance to the mission and vision of the organization. A program profile is developed by averaging individual member scores for each program.

5. Which approach should Patricia use in setting priorities for the Office of Women's Health?

We recommend using the Q-sort method to determine the priorities for the 33 health status indicators provided by the *Report Card*. In addition, we decided that there was considerable overlap with the 32 policy indicators and including the policy indicators in the procedure might confuse the participants or make it overly complex. It was really the areas (issues) that were

important along with either programmatic or policy initiatives that might be undertaken by the Office. Because the priority setting would be for discussion purposes only, statistical relevance of the Q-sort methodology (fewer that 40 items) was not considered to be critical. We have used this method quite successfully for generating meaningful discussion concerning program priority with a number of state and local health departments.

Q-sort materials can be provided to the members of the "Steering Committee" once the students have identified this method to be appropriate. The instructions presented in Exhibit 3 should be followed. These instructions are quite specific and are important for "educating" Steering Committee members in preparation for priority setting. Exhibit 2 and Exhibit 4 are developed for duplication to enable the process to run smoothly. Exhibit 2 is a log sheet for each student to record the reference number for each indicator that they place in each column. Exhibit 3 lists all 33 health status indicators on one sheet that could be duplicated and cut with a paper cutter to produce the deck of "cards" and speed the process.

EPILOGUE

Exhibit 5 below presents the resultant composite Q-sort log sheet. Within each box the top number is the program number identifier (1–33) and the bottom number represents the weighted mean score.

At the second meeting of the Steering Committee of the Office of Women's Health, the results of the Q-sort (see Exhibit 6 in this Note, where the programs are presented in order of the mean scores from the highest to the lowest and show the maximum and minimum weighted score for each health status indicator) and the composite Q-sort (Exhibit 5) were presented to committee members. The group decided to focus on the "top eleven" health status indicators as developed through the Q-sort. These indicators represented one-third of the total and everyone agreed these areas were critical within the state.

After generally discussing the women's health needs of the state and capacity of the Office (Needs/Capacity Assessment), the Steering Committee consolidated several indicators into a single priority area for the Office. It was also determined that the committee did not have adequate information concerning women's health services within the state and needed more information as to what type of services were being provided and where within the state they were delivered. Therefore, it was determined that one of the priorities of the Office would be to create a clearinghouse for information concerning women's health within Alabama. After some discussion consensus was reach on the following priorities for the Office:

Priorities based on the *Report Card*:

- Issues related to overweight (diabetes, heart disease death rate, high blood pressure, and smoking).
- Violence against women.
- People in medically underserved areas.

Priority based on the Steering Committee's experience with lack of adequate information:

- Clearinghouse for women's health services (inventory of existing programs).

It was the Steering Committee's assessment that pap smear screenings were being handled adequately by existing health department services and other institutions and that there were already a number of programs addressing infant mortality rate issues. In addition, the Steering committee felt that high school completion and women without health insurance were beyond what the Office could address with its limited resources.

REFERENCES

1. Fred N. Kerlinger, *Foundations of Behavioral Research* (New York: Holt, Rinehart and Winston, Inc., 1973), p. 582.
2. Ibid., p. 584.

EXHIBIT 1 Needs/Capacity Assessment

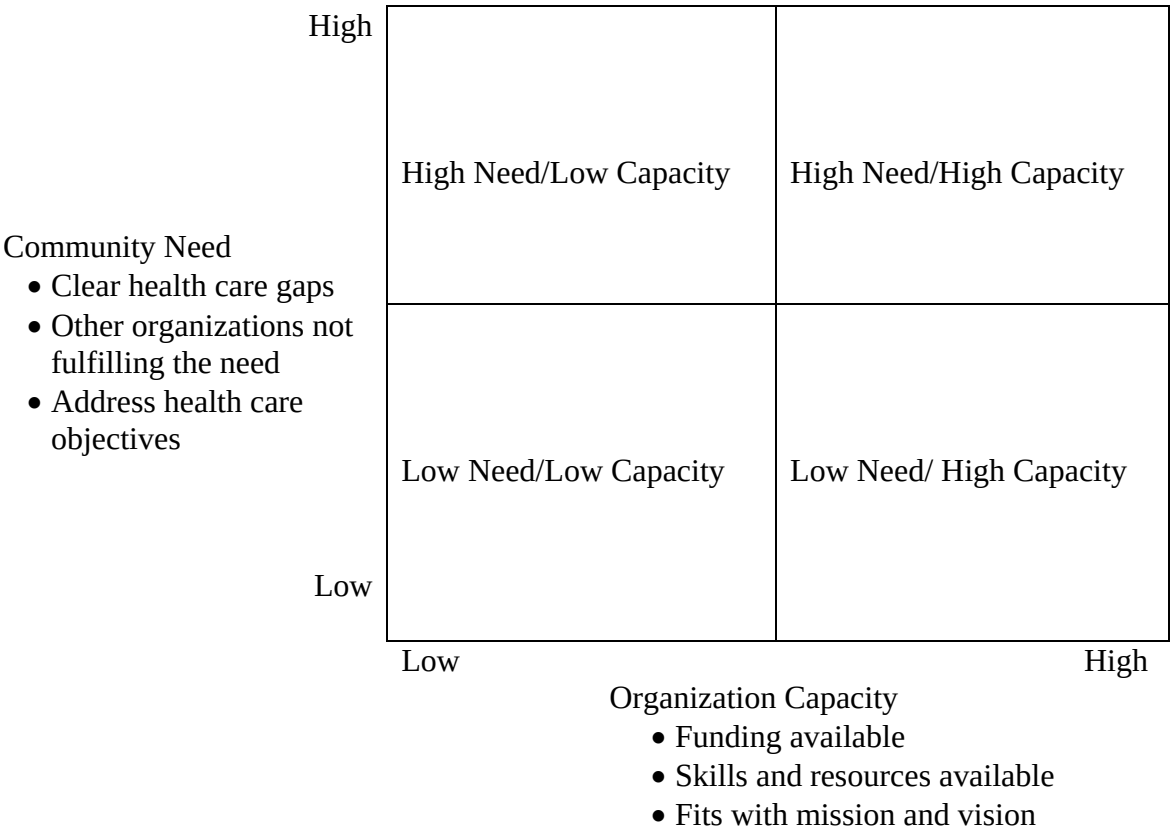
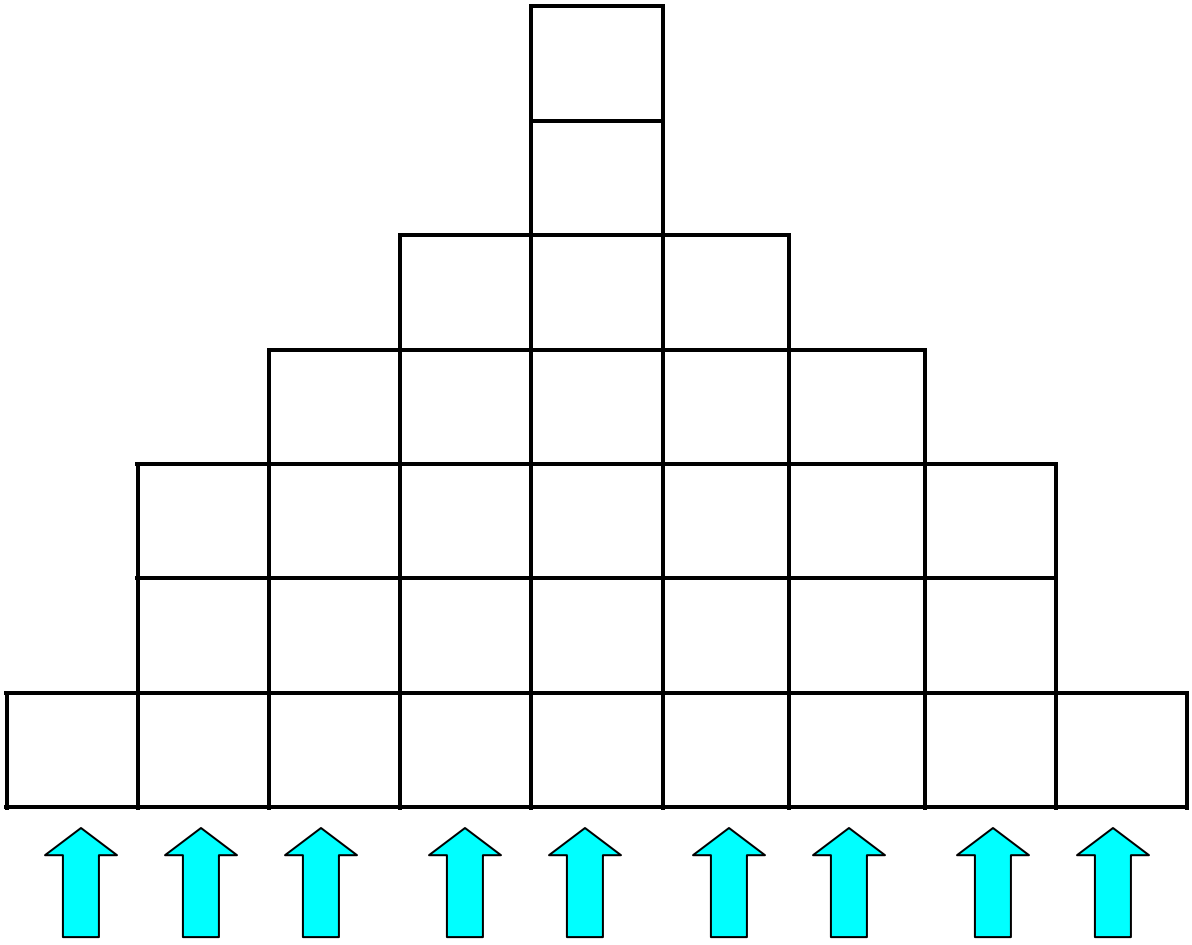


EXHIBIT 2 Women's Health Q-Sort Log Sheet

Priority Log Sheet – 33 Health Status Indicators
Health Status Indicators Priority of the Office of Women's Health



The Heath Status Indicator in this Column has the Highest Priority	The Health Status Indicators in this Column have the Second Highest Priority	The Health Status Indicators in this Column have the Third Highest Priority	The Health Status Indicators in this Column have the Fourth Highest Priority	The Health Status Indicators in this Column have the Fifth Highest Priority	The Health Status Indicators in this Column have the Sixth Highest Priority	The Health Status Indicators in this Column have the Seventh Highest Priority	The Health Status Indicators in this Column have the Eighth Highest Priority	The Health Status Indicators in this Column have the Ninth Highest Priority

Note: All Health Status Indicators within any one column have the same priority; therefore vertical order within the column does not matter.

EXHIBIT 3 Instructions for Office of Women's Health Issue Priority Setting

Materials Needed:
1 copy of the Priority Log Sheet for each student (Exhibit 2)
1 deck of "cards" for each student containing each health status indicator on a separate card (see Exhibit 4)

The instructor might say, "We are going to prioritize the women's health issues to be addressed by the Office of Women's Health. Each of you on the committee has unique expertise, perspectives, and passions concerning the issues that the Office of Women's Health should address. Although a strong case can be made for many issues, they cannot all be *the* 'highest priority.' Once we have reached consensus on the priorities of the Office, specific programmatic and policy approaches to addressing these issues within the State may be developed.

"To begin the discussion of the priorities for the Office of Women's Health, we will utilize the 2001 edition of *Making the Grade on Women's Heath: A National and State-by-State Report Card.* The *Report Card* 'grades' 33 women's health status indicators. These indicators provide a common perspective on the status of women's health in the United States as well as Alabama and serves as a basis to set priorities for the Office of Women's Health. Therefore, we will prioritize these Health Status Indicators to begin the process. In ranking the recommended priorities of the Office, you should consider the Office's purpose, women's health needs within our state, your own perspectives concerning women's health, and resource constraints.

"We will use a priority setting method that allows nine levels of priority. This procedure is particularly useful when experts are from different fields – as is the case of our Steering Committee – and we may differ on what makes one choice preferable over another. By individually ranking the Health Status Indicators using this procedure and then averaging the results of all of the committee members' rankings, we will be able to see where there is consensus and disagreement.

"To facilitate the ranking task, the 33 Health Status Indicators are printed on cards that may be arranged or sorted on a table. Each card represents a women's heath status indicator. The cards should be arranged to match the priority log sheet (Exhibit 2) that will be used to record your priority recommendations."

In determining the Health Status Indicator priorities for the Office of Women's Health:

1. Sort the 33 cards into nine columns (highest priority to the left) based on your view of the health status indicators that the Office of Women's Health should focus on first. The number of cards (health status indicators) to be placed in each column varies according to the log sheet. Thus, to rank the priorities for women's health in Alabama, the first column will have only one card and is your recommended highest priority for the Office of Women's Health. The second column will have only three cards and are the health status indicators that should be the second highest priority of the Office. The third column will have only four cards and these four indicators have the third highest priority of the Office, and so on. Note that health status indicators within any one column have the same

priority. Arranging the cards in this manner forces a "normal distribution" from highest priority, to the next highest, to the next highest, and so on.

2. After arranging the cards into the appropriate columns, record the health status indicator reference number (printed on the card) in the appropriate box on the log sheet. Health status indicators within each column receive the same scoring, so the vertical order in which you record the indicators within any one column is not important.
3. The class 'facilitator' should collect the log sheets and develop the averages to complete the exercise. Individual log sheets should be returned to participants so they can compare what their views were against the views (mean scores) of the entire Steering Committee.

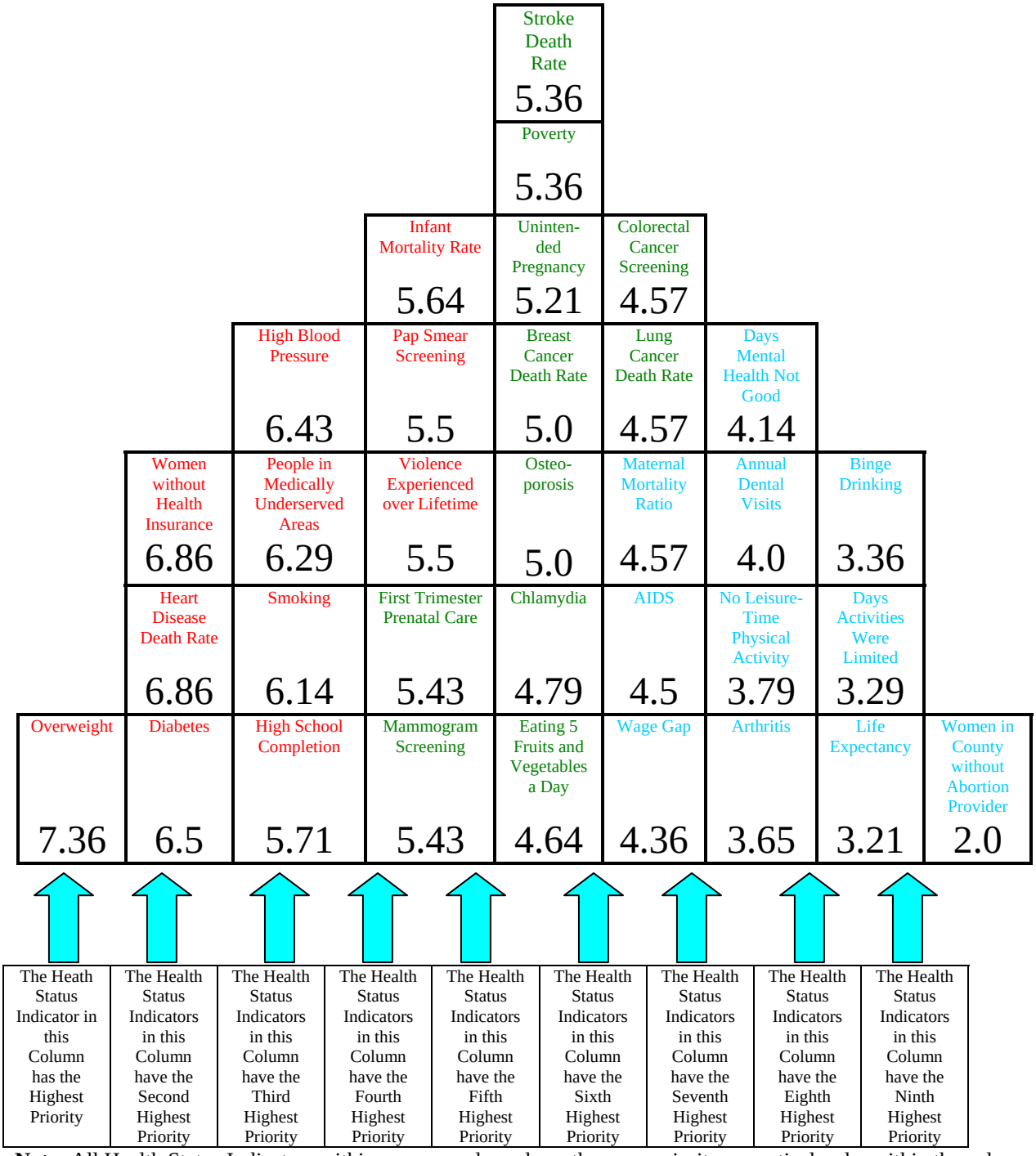
The composite log sheet is not the final health status indicator priority but rather serves as a basis for discussing priorities of the Office of Women's Health.

EXHIBIT 4

1 Women Without Health Insurance
2 People in Medically Underserved Areas
3 First Trimester Prenatal Care
4 Women in County Without Abortion Provider
5 Pap Smear Screening
6 Mammogram Screening
7 Colorectal Cancer Screening
8 No Leisure-time Physical Activity
9 Overweight
10 Eating Five Fruits and Vegetables a Day
11 Smoking
12 Binge Drinking
13 Annual Dental Visits
14 Heart Disease Death Rate
15 Stroke Death Rate
16 Lung Cancer Death Rate
17 Breast Cancer Death Rate
18 High Blood Pressure
19 Diabetes
20 AIDS
21 Arthritis
22 Osteoporosis
23 Chlamydia
24 Unintended Pregnancies
25 Maternal Mortality Ratio
26 Days Mental Health Was Not Good
27 Violence Experienced Over Lifetime
28 Life Expectancy
29 Days Activities Were Limited
30 Infant Mortality Rate
31 Poverty
32 Wage Gap
33 High School Completion

EXHIBIT 5 Composite Q-Sort for the Office of Women's Health

Priority Log Sheet – 33 Health Status Indicators
Health Status Indicators Priority of the Office of Women's Health



Note: All Health Status Indicators within any one column have the same priority so vertical order within the column does not matter.

EXHIBIT 6 Results of the Q-Sort for the Office of Women's Health

Mean	St.Dev	Max	Min	Number	Status Indicator by Mean Score Rank
7.3571	1.0818	9	5	9	Overweight
6.8571	1.9158	9	3	1	Women Without Health Insurance
6.8571	1.5119	9	5	14	Heart Disease Death Rate
6.5	1.7431	9	4	19	Diabetes
6.4286	1.3425	8	4	18	High Blood Pressure
6.2857	1.9386	9	3	2	People in Medically Underserved Areas
6.1429	1.0271	8	4	11	Smoking
5.7143	2.3674	9	2	33	High School Completion
5.6429	1.7805	8	2	30	Infant Mortality Rate
5.5	1.4544	8	3	5	Pap Smears Screening
5.5	2.2787	8	1	27	Violence Experienced Over Lifetime
5.4286	1.9101	9	2	3	First Trimester Prenatal Care
5.4286	1.2225	7	3	6	Mammogram Screening
5.3571	1.3927	8	3	15	Stroke Death Rate
5.3571	1.9057	8	2	31	Poverty
5.2143	1.9287	8	2	24	Unintended Pregnancies
5	1.1767	7	3	17	Breast Cancer Death Rate
5	0.8771	7	4	22	Osteoporosis
4.7857	1.9682	9	2	23	Chlamydia
4.6429	1.9457	8	2	10	Eating Five Fruits and Vegetables a Day
4.5714	1.2839	6	2	7	Colorectal Cancer Screening
4.5714	1.4525	7	2	16	Lung Cancer Death Rate
4.5714	1.989	8	1	25	Maternal Mortality Ratio
4.5	1.6525	7	2	20	AIDS
4.3571	1.9457	8	1	32	Wage Gap
4.1429	1.4064	6	2	26	Days Mental Health Was Not Good
4	1.4142	6	2	13	Annual Dental Visits
3.7857	1.8472	8	2	8	No Leisure-time Physical Activity
3.6429	0.9288	5	2	21	Arthritis
3.3571	1.3927	6	1	12	Binge Drinking
3.2857	1.4899	6	1	29	Days Activities Were Limited
3.2143	1.5281	7	1	28	Life Expectancy
2	1.4676	5	1	4	Women in County Without Abortion Provider

CASE 10

The Rosemont Behavioral Health Center

OVERVIEW

Lloyd Lewis purchased The Rosemont for $1 million with funds from his brother, Cates Lewis. The Rosemont, a behavioral health center that was primarily an inpatient facility for the treatment of addictions, was in trouble. A member of the board called Cates to tell him there was insufficient cash to meet payroll. Because Lloyd had told him everything was "fine," Cates admitted that he had been "slack" as a board member. Cates arranged for a $3 million line of credit and began to investigate the problem; however, he had his own successful publishing company to run.

By the time Cates met Charles Brown, most of the $3 million line of credit had been used. Charles Brown, a health care consultant, agreed to make a two-day site visit to determine whether he could help The Rosemont. He recommended that two levels of intervention were needed: a comprehensive crisis management program to reduce costs and increase short term revenues and a long term strategic plan to position the organization for the future. Charles was hired with a nine-month contract at a cost of $25,000 per month. His first decision was to employ a turnaround specialist, Matthew Ibrahim, as a contract CEO. Matthew outlined the problems he uncovered in the first several weeks and informed Charles that there simply were not enough patients coming through the door to cover costs. Matthew suggested that marketing expertise was needed to help fill beds. A marketing firm was hired and performed a marketing audit. With so many possible alternatives, some significant undertakings and some rather simple, the student is to determine what should be done to turn The Rosemont around – if it can be done.

Note: This case is based on a real situation; however, the names of the organization, its location, and all players have been disguised. The financial data is accurate.

KEY ISSUES

1. A turnaround strategy for a health cares organization in financial distress.
2. Balancing short term fixes to keep the doors open versus longer-term strategic management.
3. External changes in this segment of the health care industry are threatening survival of many organizations.
4. An organization's structure impacts its ability to succeed.
5. Board selection, management, and responsibilities.

This teaching note was written by Phil Rutsohn and Bob Forget, Marshall University. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

TEACHING OBJECTIVES

After analyzing this case the student should be able to:

1. Determine the break-even point for The Rosemont to decide whether a turnaround is possible.
2. Develop a list of short-term crisis management interventions.
3. Develop a strategy for The Rosemont to survive or decide to close it down.
4. Understand the advantages of a corporate board structure for a health care organization.

SUGGESTIONS FOR EFFECTIVE TEACHING

The Rosemont is not alone in its current crisis. Many behavioral health organizations are struggling. The keys to future success for psychiatric centers are outpatient services and expansion into multiple complementary services. The Rosemont must cut costs, provide needed services, improve its structure, and keep prices affordable in the local market.

We have found role playing to be very effective for this case. A meeting of the board can be "called" to decide whether or not to hire Charles Brown. His fees, in light of the dire financial straits of the organization, are high at $25,000 per month. His requirement that he be able to purchase into The Rosemont at 13 percent of ownership would make him the second largest shareholder (after Cates) and change the entire dynamics of the board. Several of Lloyd's buddies should vehemently be opposed to any changes. How the student role-plays Cates – the bully big brother, the successful businessman, the logical individual, and so on – will depend on how the other students play their roles.

After the decision is made to hire Charles Brown's firm (everyone knows that there is only one conclusion because the financial situation is dire), the class should take a break and reconvene the board meeting approximately two months later when Charles is making his presentation about the changes that he recommends. One student could be "Charles" as he presents the short-term fixes and another could be asked to be "Charles" as he presents the strategic changes that must be made.

Another method is to hand a stick to a student and indicate that he or she is now "Charles." Charles then presents his recommendations until he has no more (or the student can be asked to present one recommendation) and then hands the stick off to another student who develops additional recommendations (or adds one more recommendation). If the class is large, having a student present a single recommendation allows for greater participation.

Alternatively, this case works well as an exam case. Specific questions, such as those in the Question for Class Discussion section, can be asked of students when the time for the exam is short or they can merely be assigned to analyze the case.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

The following internal strengths and weaknesses and external opportunities and threats have been identified for The Rosemont.

Strengths	Weaknesses
1. Adolescent treatment at Bay Saint Louis	1. Cash flow is non-existent
2. Lloyd Lewis's experience as a counselor	2. Incompatible computer systems
3. Buildings could be modified to double the number of patients	3. Patient mix is 90 percent Medicaid / Medicare
4. Value of the fixed assets	4. Incompetent managerial employees
5. Knowledge of the trends impacting mental health and substance abuse	5. Focus on inpatient treatment when outpatient care is growing
6. Medical director of Rosemont–Jackson	6. Informal, reactive marketing efforts
	7. Low employee morale
	8. Pay-scale below community norms

Opportunities	Threats
1. Alcohol and drug abuse continues	1. Bank foreclosure
2. The frantic pace of life	2. Drop in demand for psychiatric services
3. Impact of economic downturns	3. Declining lengths of stay
4. Outpatient treatments	4. Loss of Medicare/Medicaid certification
5. Companies have determined that substance abuse treatment costs less than lost productivity	5. Managed care deletes behavioral health coverage

STRATEGIC ALTERNATIVES

Contraction / divestiture – Would one of the national chains be interested in buying any part of The Rosemont? Would the local hospital? The community would have to be strategically located for a particular behavioral health chain to be interested in The Rosemont. Certainly they would not be interested in paying $4 million (Cates's investment).

Contraction / liquidation – The Rosemont owes $4 million and its assets are $2.5 million meaning that Cates Lewis will lose $1.5 million.

Combination strategy – contraction/retrenchment followed by maintenance/ enhancement.

Combination strategy – contraction/retrenchment followed by expansion/product development.

QUESTIONS FOR CLASS DISCUSSION

1. Exactly how dire is the situation for The Rosemont?

The best students will use data from the case and determine a break-even number of patients per month to compare against the actual number of patients staying at The Rosemont per month.

The Rosemont is currently operating at 20–25 percent occupancy. Because of the limited, questionable, and poorly organized financial data, students will have to make some assumptions. However they should be able to generate a break-even analysis somewhat like the following.

The Rosemont's current approximate monthly fixed costs include:

Corporate management	$50,000
Management at each of the facilities	100,000
Interest-only payments on debt	30,000
Contract payment to TM (Charles Brown)	25,000
Other fixed costs including: insurance, taxes, other support personnel, automobiles, etc.	95,000
Total monthly fixed costs	$300,000

The average reimbursement rate for each patient day at either of the facilities is $250.

After subtracting the variable costs that are currently 40 percent, The Rosemont has a unit contribution from each of these reimbursed patient days of $150.

By dividing The Rosemont's monthly fixed costs ($300,000) by its average unit contribution margin ($150), a monthly break-even of approximately 2,000 patient days is calculated.

The Rosemont has a total of 4,500 patient days available (150 beds x 30 days) each month. Dividing the break-even patient days of 2,000 by our available patient days of 4,500 indicates that The Rosemont has to operate its facilities at approximately 44 percent occupancy to break even.

Because the Rosemont is operating at 20–25 percent occupancy and has been for some time and needs to be at 44 percent to simply break even, it is definitely on the verge of bankruptcy. The 20–25 percent occupancy is an intolerable figure based on the organization's current level of fixed costs. The organization must reduce costs and increase its patient days to survive.

2. What short-term "fixes" should be implemented immediately at The Rosemont?

Because cash flow is non-existent, the first issue that must be addressed is cost cutting. However, cutting costs alone will not enable The Rosemont to survive. It needs more patients as well. Students normally come up with a number of cost-cutting activities that should be

done immediately. At the very minimum, $60,000 per month has to be eliminated to have revenues equal expenses.

Short-term Cost Containing Fixes

- Restructure management personnel and close the corporate offices.
- Reduce administrative staff (currently enough staff for full occupancy when the occupancy rate is 20 to 25 percent).
- Maintain one chief of nursing for both facilities.
- Aggressively collect and factor accounts receivable. Accounts receivable are noted in the case as being high. The computer system went down and in fact was not operational for several months. By the time the computer system was up and running, patients had not been billed for six months. Therefore non-delinquent accounts were six months old! No telling how old the delinquent accounts were. Management should immediately sell the accounts receivable for whatever can be obtained (called factoring accounts receivable). It will probably not be much but still better than what they currently have. This expensive mistake is a write-off and anything will be better than nothing. Factors pay based on the "age" of the delinquent accounts and the likelihood of collection.
- Have the competent Jackson facility comptroller take over that position for Bay Saint Louis as well.
- Update and re-negotiate managed care contracts. As indicated earlier, there are a significant number of managed care contracts between The Rosemont's various payors; however, many of these are out of date. In addition, the pricing structure needs to be evaluated for each contract. One full time position may be allocated to establish contacts, communication, and contract negotiations with managed care providers.
- Immediately begin keeping and analyzing financial data for each facility separately.
- Immediately stop paying on the lease car of the previous CFO (at minimum it will cut the insurance and maintenance costs even if it is parked until the lease is up).
- Immediately validate lengths of stay with insurors to determine patient coverage before admission.
- Immediately develop and implement uniform policies for petty cash, accounts payable, and purchasing.
- Immediately investigate consolidation of the various telephone systems and as soon as contractually feasible, act to cut costs.
- Immediately cancel cell phones or at a minimum implement a policy of no personal calls.

Short-term Revenue Generating Fixes

- Train employees to close the sale. The Rosemont has no idea how many patients are "lost" because there are no records of the number of potential patients calling in matched with how many actually show up at the door. The key phrase here is "showed up at the door." There was no effort made by the telephone operators to "make the sale" by motivating the person to come in right at that moment or for The Rosemont to go out and pick up the individual. There should have been a formal procedure established to ask the patient if he or she had transportation to the facility, when they could be expected to arrive, etc. If the individual did not have

arrangements, then Rosemont personnel should be dispatched to transport him or her to the facility.

- Organize the marketing people to do marketing. Although there are positions identified for marketing there are no clear guidelines for authority, responsibility, and accountability. With a clear delineation through comprehensive job descriptions and specifications, the efficiency and effectiveness of the marketing personnel could be enhanced significantly. Specific responsibility for everything from mass media advertising to public relations to referral development must be identified and tasks assigned to specific positions.

  For each position, time allocation and expected outcomes must be identified. Currently, marketing activities by operating personnel are accomplished on an "as time permits" basis. The management problems associated with this orientation are obvious.

  Although there is no funding for marketing studies at this time, there are nonetheless some things that can and must be done. An important first step is to determine the current patient base. Expanding the number of patients is very difficult if marketers do not know who the current customers are.
- Where do patients come from? Patients' zip codes can be determined from admission forms or billing statements. Normally this information could be accessed by computer, but given that the computer systems are incompatible, students should surmise that it is unlikely that this task can be done electronically. However, at the current low occupancy rate, it cannot be that big of a task to track down the zip codes.
- Who refers the patients? If this information has not been collected at admission, it must be initiated as standard policy immediately. For those patients whose admission data includes the referral, a list should be developed of those physicians, therapists, and independent marketing contractors (IMCs) that have referred to The Rosemont most frequently. Visits should be made to encourage them to continue to refer to The Rosemont. Data could be collected during these visits about the additional needs of the referral source for other patients that they might not have recommended for The Rosemont.
- What do the patients come for? Specific treatments used and those desired but not available at The Rosemont should be collected into a report for future decision making.
- How long do they stay? Length of stay is important information for reimbursement as well as outcomes measures. Gone are the days when insurors paid for a month's stay for alcohol abuse or drug addiction. If a long stay is truly required and The Rosemont is performing this community service without sufficient compensation, then external fund raising should be considered.
- What is the collection experience with each? Payment methods and delinquencies must be brought up-to-date and used in decision making in the future. Some patients should not be "encouraged" to stay at The Rosemont.
- Establish a line item budget for marketing. Personnel costs are identified for marketing but other costs (advertising, etc.) are homogenized under a variety of account titles. There should be an identification of resources for advertising (mass media), referral development, personal selling, and so on. To evaluate performance and effectiveness, the organization must be able to identify where funds are flowing and specific outcomes associated with this flow of funds.

- Develop an assessment tool for evaluating independent marketing contractors. The Jackson facility has made effective use of independent marketing contractors (IMCs). These firms represent an excellent opportunity for outsourcing the responsibility for inpatient referrals. The organization should ensure that each IMC is reputable and is channeling only those patients to The Rosemont who can truly benefit from its services. The development of assessment criteria for entering into a partnering relationship with IMCs will reduce the risk of becoming involved with body snatchers. Limited information inhibits a comprehensive analysis of current contract arrangements with IMCs, but it appears (based on a global break-even analysis) that the Jackson facility is doing an effective job of negotiating financial agreements with IMCs.

  The IMCs who currently provide inpatient referrals do not appear to be making outpatient referrals. Unless there is a statutory reason for this, the policy should be changed to enhance the outpatient business as well.

3. What strategies are available to The Rosemont?

Once costs have been cut and cash flow re-established (the contraction strategy), then various maintenance of scope and expansion of scope strategies can be undertaken. A number of alternatives exist.

Maintenance of Scope/Enhancement Strategies

- Develop a comprehensive marketing plan. The organization must reduce to writing its distinct competencies/expertise, how it is perceived in the market, the competition, what the current patient base is, and where the market is going. From this type of information, strategies need to be developed that will not only stimulate current demand, but also strategically position the organization for the future.
- Restructure the organization. The organization is not sufficiently large to warrant a headquarters staff and an operating staff. Jobs need to be consolidated for top-level positions, reducing the high cost of management.
- Renovate the Jackson facility and identify potential new locations for the Bay Saint Louis facility. Although the lobby and other common areas at the Jackson facility present a positive quality image to potential patients and payors, patient rooms, hallways and the like are in need of significant renovation. At a minimum, the facilities need to be upgraded in such a way that they at least meet the minimum standards for Medicare. It is not likely that the organization would be able to classify space as "office" if patients are using it. Assuming that cash flow can be increased in the immediate future, major renovations need to be on the distant horizon.

  The Bay Saint Louis facility potentially could become an outstanding facility with considerable historic value; however, the cost of renovation would be extremely high demanding a significant increase in its prices. A more viable alternative to the organization would be to identify an alternative location.
- Develop criteria for evaluating satellite ambulatory programs. Market development and market penetration strategies for satellite programs appear to have been intuitively determined. Although intuition may have resulted in the best geographic selection and the best penetration strategies there is no evidence that an organized evaluation has been done. With a change in marketing strategies, could patient

demand be increased substantially in each market? Or is the market potential limited? Is the Company maximizing its return for each of these programs? Without criteria and comparative data it is difficult for management to address these questions.

- Consolidate the computer and accounting systems.
- The Rosemont needs to perform an internal analysis – an objective assessment of itself. The following questions need to be answered:
    - What is The Rosemont's real expertise?
    - What are its distinct competencies?
    - What is its perception in the market? In the community?
    - Who are the direct competitors for The Rosemont? The indirect competitors?
    - What programs are needed in each of their markets?
    - Can patient needs be satisfied in ways that are different from current operations?
    - Can The Rosemont modify what it is doing to target new and different patients?

Expansion of Scope/Product Development Strategies

- Develop outpatient (ambulatory) substance abuse care as a distinct product. As it has become for most health care, ambulatory care is the growth market for substance abuse and mental health in general. The competition for inpatient admissions will continue to increase as the patient base becomes smaller and smaller. It will become imperative to project the right image to payors. Although "packaging" does not determine quality care, the lack of appropriate packaging inhibits the perception of quality. Until the Rosemont has funds to renovate the Jackson or Bay Saint Louis facilities, priority should be given to initiating a strong outpatient program immediately. This program will improve cash flow and provide a financial base for renovations.

  The organization has an opportunity to develop a distinct competency in this area and should aggressively pursue the strategy. Because the facilities available do not appear to be conducive to attracting insured patients, consideration should be given to off-site locations for the program. The target market for the program should incorporate two segments of the population in the immediate future: comprehensively insured middle income individuals and professionals who would benefit from participating in a program with cohorts.
- Increase marketing efforts in Bay Saint Louis to capture the adolescent market. Rosemont–Bay Saint Louis is identified in the community as an excellent program for adolescents. Adolescent care provides an opportunity for the organization to develop a distinct competency not only in the immediate area, but also potentially throughout the state and region. Adolescent care should not be limited to programs funded by state and local governments but rather should incorporate a comprehensive market to include managed care contracts, direct contracting, and insurance companies. A significant increase in mass media, personal selling, public relations, and referral development targeted toward the adolescent market was needed to enhance this market (product development) or for new locations around the state (market development).

- Develop and initiate an employee assistance program. A comprehensive program focused on a holistic approach to substance abuse and mental health should be developed and marketed primarily to mid- and small-size businesses. As a new product for The Rosemont, an employee assistance program (EAP) would require resources and a plan. The number of mid- and small size companies in the area, the number of competitors, and the amount of capital available to support the new product will determine whether this is a viable alternative.

4. What would you recommend to Cates about The Rosemont board of directors?

Some of the board activities border on the illegal; certainly they are not ethical. Specifically, the accounting firm that did the annual audit of the organization has two principals sitting on The Rosemont board – not exactly an arms-length relationship.

Board members apparently were selected by Lloyd based on their golfing game. Particular areas of expertise that would be expected of a corporate-type board did not occur. Neither was the board really a community-type board as the members were not noteworthy in their fund raising and nor were they donating large sums to The Rosemont. It appears as though no one on the board was being fiscally responsible (including Cates, whom we would expect more from as he ran a successful publishing company).

EPILOGUE

The Rosemont still exists, but it is hanging on by a thread. The crisis management team improved cash flow sufficiently to keep the organization afloat. Things that were done immediately included:

- Writing off every dollar in accounts receivable,
- Closing the corporate offices and relocating them to the Jackson facility,
- Eliminating any personnel not performing to the organization's expectations,
- Appointing one director of nursing to handle both facilities,
- Negotiating with IMC agents to direct more patients to the facilities, and
- Training telephone operators to be more proactive and literally send transportation to immediately pick up troubled clients who called and bring them to The Rosemont.

The Rosemont has yet to implement any strategic plan and it is rumored that the board composition changed. Charles Brown did not exercise his option to buy 13 percent of The Rosemont.

CASE 11

Riverview Regional Medical Center: An HMA Facility

OVERVIEW

Riverview Regional Medical Center (RRMC) was a 281-licensed bed inpatient facility located in Gadsden, Alabama. RRMC essentially shared the immediate service area with three other facilities: Gadsden Regional Medical Center (GRMC), Mountain View Hospital, and HealthSouth. GRMC operated 248 beds, but made about 1,300 more admissions than RRMC in 2003. Mountain View, a psychiatric and chemical dependency facility, was not a direct competitor for the general acute care facilities. HealthSouth did provide competition, especially in the outpatient arena.

Gadsden was approximately 60 miles from Birmingham, a metropolitan area that incorporated more than twenty hospitals, including the University of Alabama at Birmingham (UAB) Hospital and several nationally renowned specialty facilities. Therefore, out migration to these urban facilities was a significant issue.

RRMC, formerly owned and operated by an order of Catholic nuns, was acquired in 1991 by Health Management Associates (HMA), a proprietary chain based in Naples, Florida. Matt Hayes became Executive Director in October 2003. His predecessor had closed the Women's Pavilion in March 2003 and discontinued the obstetric service line. Because the Pavilion had opened only two years previously, the closing created the perception in the community that RRMC was in financial distress. Furthermore, it strained the relationship between management and the medical staff. Mr. Hayes faced these new challenges along with continuing issues related to protecting and improving market share.

KEY ISSUES

1. Responding to a turbulent health care environment that mandates alternatives to traditional inpatient services as the major source of revenue.
2. Creating a market niche in a limited geographic area with a declining population base, where the primary competitor has a larger market share and is better staffed.
3. Very strong competition outside the immediate market because out migration provides access to advanced, high-technology services at a world-renowned medical center.
4. Managing community perceptions of the organization's viability.

This teaching note was written by Woodrow D. Richardson, Ball State University, and Donna J. Slovensky, The University of Alabama at Birmingham.

5. Restoring damaged relationships between management and the medical staff (resulting from the closing of the Women's Pavilion).

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Identify and discuss current and emerging environmental issues that impact health care organizations in general and RRMC in particular.
2. Discuss growth strategies for inpatient health care organizations when increasing admissions is not a viable alternative.
3. Propose and evaluate strategies for this challenger organization in the service area to survive and grow.
4. Develop a plan for RRMC to meet HMA's objectives.

SUGGESTIONS FOR EFFECTIVE TEACHING

Although some general references are made to trends and issues in the health care environment, this case lacks an adequate foundation for rigorous analysis within the context of the health care industry. If students have not had sufficient health administration preparation (either academically or experientially), the case should be preceded by appropriate lecture, discussion, or other pedagogy to provide the necessary foundation (for example, assign Case 1).

Case analysis may be focused on the strategic alternatives available to RRMC. Students should be encouraged to develop a TOWS matrix prior to responding to the questions posed at the conclusion of the case. There are no "correct" answers to the questions. They are intended to stimulate discussion of alternative courses of action. For some questions, the options posed will be limited only by the student's creativity and willingness to investigate alternative modes for delivery of health care services.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Riverview's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths	Weaknesses
1. Affiliation with a financially stable, successful parent corporation with demonstrated entrepreneurial skills.	1. Shared medical staff is not conducive to securing physician loyalty.
2. Proprietary management information system and network.	2. Medical staff is resistant to developing new provider relationships.
3. Management expertise in improving billing, collections, and productivity.	3. Most physician practices are physically separated from the hospital; GRMC physicians lease space in its on-campus professional office building.
4. Medical staff and clinical service	

structure is conducive to full-service health care.

5. Recently renovated facility that includes state-of-the-art technology, and has capacity for growth.

6. Experience in implementing innovative patient-oriented programs.

4. Damaged relationship between management and the medical staff.

Opportunities

1. Increasing consumer and payor demands for lower cost health services.

2. Industry trend toward simple, comprehensive, direct arrangements between providers and consumers.

3. Low managed-care penetration in the market service area and the region in general.

4. Local economy is manufacturing based.

5. Gadsden is the largest health care center for three adjacent counties.

6. Incidence of chronic diseases and conditions in the general population.

Threats

1. Aggressive competition from GRMC.

2. Out migration of current and potential patients to Birmingham health care market.

3. Declining population in Gadsden.

4. Increased regulation of all health care services.

5. Medicare and Medicaid reimbursement practices.

6. Community image problems associated with closing the Women's Pavilion and eliminating obstetrics services.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

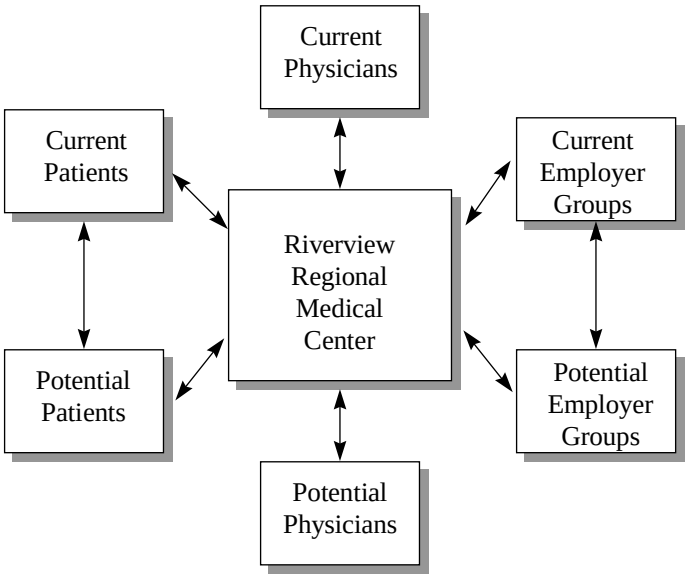
1. Expansion/market development – The corporate office (HMA) has been pursuing this strategy through market entry/acquisitions. Growth or maintenance of scope as strategic decisions after "turnaround" were decentralized to the individual administrative teams.
2. Expansion/market penetration – Attracting patients (in the historical service area) who currently use GRMC or travel to Birmingham as well as those with unmet health needs.
3. Expansion/market development – Extend the primary market area to include adjacent Cherokee and DeKalb counties.

4. Expansion/product development – Develop an industrial medicine program to tap the manufacturing base of Etowah county.
5. Maintenance/enhancement – Better serve the current patient population by strengthening the network of service relationships.

QUESTIONS FOR CLASS DISCUSSION

1. Construct a simple stakeholder map for Riverview Regional Medical Center. Discuss the target markets of existing programs and identify gaps in RRMC's marketing strategy.

Stakeholder Map for Riverview Regional Medical Center



The One Call Scheduling program is targeted at physicians and group practices. Students should recognize that making calls to each diagnostic area is not efficient for physicians' office staff, and it can be frustrating to patients if appointments are not scheduled in blocks. The hospital should promote centralized resource scheduling as enhanced service to both patients and physicians.

The MedKey program is targeted at employers and patients. However, the patients seem to be the primary recipients of membership perks associated with the program. Area merchants benefit from the affiliation by gaining name recognition. Benefits to employer groups may need to be reconsidered to strengthen the number of group members in the program.

The Nurse First program is targeted at patients. This program emphasizes immediate access to needed treatment before administrative processing occurs. This program reinforces Mr. Hayes' commitment to the ER as the "front door" of the hospital.

RRMC appears to have prioritized physicians and patients as its key stakeholders. Possibly, the CEO should consider changes in the relative power of employers and employer coalitions in his stakeholder management strategies.

Note: If students need introductory information about stakeholders, stakeholder maps, and stakeholder management strategies, we suggest *Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders* by John D. Blair and Myron D. Fottler (Jossey-Bass, 1990).

2. Develop a TOWS matrix for Riverview Regional Medical Center. What strategic alternatives are suggested by the matrix?

A TOWS matrix provides a conceptually simple mechanism to investigate strategic alternatives. The matrix summarizes an organization's internal strengths and weaknesses on the horizontal axis and its external opportunities and threats on the vertical axis. The format provides easy visualization for comparison of strengths with opportunities and threats, and weaknesses with opportunities and threats. Interactions among the four sets of variables suggest strategic alternatives.

TOWS for Riverview Regional Medical Center

	Internal Strengths	**Internal Weaknesses**
	1. Corporate financial strength and entrepreneurial skills 2. Management info system 3. Expertise in productivity improvement 4. Full service medical staff 5. Physical plant has extra capacity 6. Innovative patient-oriented programs	1. Shared medical staff not conducive to developing physician loyalty 2. Medical staff resistance to alliances and other provider relationships 3. Physician practices are geographically separated from RRMC 4. Damaged relationship between management and medical staff

External Opportunities 1. Employers need lower cost health benefits 2. Trend toward direct provider–consumer arrangements 3. Low managed care penetration 4. Industrial economy; however no industrial medicine programs exist 5. Gadsden is the largest health care center for three adjacent counties 6. Incidence of chronic diseases and conditions in the general population	Future Quadrant: <u>Market Development</u> • Use MedKey to establish links with local businesses • Market to adjacent counties • Market to businesses more aggressively <u>Related Diversification</u> • Industrial medicine; work hardening program • Cardiac rehabilitation conditioning; fitness center • Outpatient therapy programs • Outpatient diagnostic services • Home care programs	Internal Fix-it Quadrant: <u>Product Development</u> • Investigate information system-based business solutions • Build referral network with primary care providers in adjacent counties <u>Enhancement</u> • Market the "patient-oriented" concept evident in Nurse First, MedKey • Consider information system linkages with medical staff office systems • Phician Leadership Group
External Threats 1. Competition from GRMC 2. Out migration to Birmingham 3. Declining population 4. Increasing regulation 5. Medicare and Medicaid funding changes 6. Community image problems	External Fix-it Quadrant: <u>Enhancement</u> • Promote quality services as recognized by HealthGrades • Speak to civic groups – increase visibility and improve consumer knowledge about facility services	Survival Quadrant: <u>Market Development</u> • Promote "either facility – same physician" in marketing strategy • Investigate out-migration patterns and target services where competition is both desirable and feasible • Decrease dependence on Medicare/Medicaid

Source: TOWS matrix format modeled by Heinz Weihrich, "The TOWS Matrix: A Tool for Situational Analysis," *Long Range Planning* 15, no. 2 (1982), p. 60.

3. What new services or products could be developed with existing resources?

Students who research the demographics of the geographic area should learn that the economy in Gadsden and Etowah County is based primarily on manufacturing. This suggests that a significant portion of health care services in the area may be work-related illnesses and injuries, employment physicals, and other industry-driven health services. This knowledge may lead students to suggest service lines appropriate to such a market. Likely suggestions could include industrial medicine services such as treatment for work-related illness or injury, physical examinations, safety education, and drug screening. A second alternative could be a work hardening program, where patients typically are referred following Worker's Compensation claims. Work hardening programs are staffed primarily by physical and occupational therapists. Student should consider the availability of licensed personnel to staff these programs.

Students should consider other services that can be incorporated into the new diagnostic center, perhaps including some women's diagnostic services such as mammography. Suggestions other than diagnostic services could include contracting with local employers for pre-employment physical examinations, drug screening, etc., or health screening for individuals or businesses, perhaps through MedKey membership.

4. What services need to be strengthened and promoted to control out migration from the primary service area?

No "quick fix" answer exists for this question. The student should identify information needs and potential sources of information necessary to formulate a strategy. First, Mr. Hayes should identify services where growth is both desirable and feasible — those where physical resources and staff currently exist or can be readily acquired. Second, knowledge of existing out migration volume and patterns for the identified services must be determined. Third, data should be reviewed to determine whether services equivalent to those provided in the Birmingham facilities are available at RRMC. Information analysis should suggest two questions: "Does RRMC want to develop services not currently available in Gadsden to compete with Birmingham providers?" and "Does RRMC want to promote the identified existing services as desirable alternatives to Birmingham providers?" Answers to these questions are necessary prior to formulating a strategy to control out migration.

5. What should RRMC do to counter its image problem in the community because of its decision to close the Women's Pavilion?

Although Mr. Hayes did not create this problem, he most certainly inherited it. Students will undoubtedly suggest a public relations campaign, probably via TV, radio, and newsprint, touting RRMC's HealthGrade ratings and the variety of services it continues to offer the community. Students should be pressed to "cost out" such a program. Some students will recommend a more hands-on approach utilizing Mr. Hayes as the point person speaking to various civic groups throughout the community. Information can also be made available via the hospital's website. The same information as the media blitz approach could be conveyed using Mr. Hayes and his staff at a minimum cost to RRMC.

6. What can Mr. Hayes do to improve the relationship with the medical staff?

The ability to build and maintain a good working relationship between the medical and administrative staffs is a key success factor for health care executives. The fact that the hospital–physician relationship at RRMC was damaged because of a decision made by the previous CEO does not mitigate Mr. Hayes' responsibility to minimize the fallout and rebuild a productive partnership. The Physician Leadership Group (PLG) is a visible, formal commitment to involving the medical staff in the strategic affairs of the hospital. Business and clinical decisions underlying the hospital's strategy should be made with both physicians and administrators committed to providing quality patient care and services. Through the PLG forum, physicians can be educated about issues associated with the business transactions of the organization, and

information can be gained from the physicians about their clinical issues and community health goals.

Recommendations for tactics Mr. Hayes can use should focus on increasing the business information made available to the medical staff, providing for medical staff "voice" in strategic decisions, and open communication from both sides about how and why specific decisions are made. Examples of appropriate recommendations include appointing physicians as ad hoc members of administrative committees, presenting regular "strategy updates" at medical staff meetings, and routinely sharing results of environmental scanning and strategic issue analyses with the medical staff.

CASE 12

AIDSCAP Nepal

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 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, were 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

This teaching note was written by Ven Sriram and Franklyn Manu, Morgan State University.

condom use.
4. The impact on public health judgments because 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

After analyzing this case, the student should be able to:

1. Understand 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. Understand the complexities of social marketing – particularly an issue that is as sensitive as HIV and AIDS.
3. Use of inadequate market research data – interpreting and making inferences from study results.
4. Evaluate marketing research that has already been done, redesign an improved study, and determine whether the cost/benefit justifies conducting a further study.
5. Develop 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, 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 (such as from WHO and UNAIDS) to fully grasp the extent of the problem. For instance, data from India indicate 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 12/2 through 12/5 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 12/4 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 12/1) is not too dissimilar from that of the respondents of the 1996 rapid assessment (Exhibit 12/10). 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 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, namely that comparisons across studies are often difficult because data are categorized differently. For example, the age groupings for CSW clients in the 1994 study are different from those used for CSWs and also from those 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.)

AIDS Awareness and Risk Perceptions
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 12/4) and the 1996 study (Exhibit 12/12) show 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.

These data suggest 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 12/2 and 12/3) with the 1996 assessment (Exhibit 12/11) 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 12/3) and 1996 (Exhibit 12/11) indicate 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 12/13, 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), 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 (such as government sponsored informational programs and 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 to isolate the behavior of "regular" CSWs from the more "casual" ones 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 12/10), further limits the use of mail surveys. Lack of availability of databases 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 such as 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, and 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, and 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 12/7, 12/8, and possibly 12/9, 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, and so on) 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 – anywhere 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, and

- 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 12/7, 12/8 and 12/9 provide the information necessary to determine a budget and select the media. Exhibits 12/5 and 12/13 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 achieve the following goals:

- 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 12/9 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 12/7 and 12/8 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 a population of 19 million. 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 12/13, 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 that 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 a 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 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 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.