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1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE NOVEMBER 1992		3. REPORT TYPE AND DATES COVERED FINAL REPORT (07-91 to 07-92)	
4. TITLE AND SUBTITLE A STUDY ON HOW TO IMPLEMENT AN EFFECTIVE MARKETING AND EDUCATION PROGRAM FOR COORDINATED CARE				5. FUNDING NUMBERS	
6. AUTHOR(S) MAJOR DAVID A. COKER, MS					
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) FITZSIMONS ARMY MEDICAL CENTER AURORA, CO				8. PERFORMING ORGANIZATION REPORT NUMBER 5a-92	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) US ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL BLDG 2841 HSHA MH US ARMY BAYLOR PGM IN HCA 3151 SCOTT ROAD FORT SAM HOUSTON TEXAS 78234-6135				10. SPONSORING/MONITORING AGENCY REPORT NUMBER	
11. SUPPLEMENTARY NOTES					
12a. DISTRIBUTION AVAILABILITY STATEMENT APPROVED FOR PUBLIC RELEASE; DISTRIBUTION IS UNLIMITED				12b. DISTRIBUTION CODE	
13. ABSTRACT (Maximum 200 words) The Department of Defense is committed to introducing managed care to the military health care system via the Coordinated Care Program. The Army Medical Department has taken the lead in the Department of Defense through the implementation of its Gateway to Care program. These programs represent a radical departure from the military health care system of the past and the manner in which they are implemented may well determine the future of military medicine. This study describes the process involved in developing a health care marketing plan at Fitzsimons Army Medical Center. It identifies opportunities available to Fitzsimons and provides an action plan to accomplish the established marketing objectives. Upon the completion of the marketing action plan, the process for the approval and monitoring functions is discussed. *Original contains color plates: All DTIC reproductions will be in black and white*					
14. SUBJECT TERMS MARKETING AND EDUCATION; GATEWAY TO CARE; COORDINATED CARE				15. NUMBER OF PAGES 66	
				16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT N/A	18. SECURITY CLASSIFICATION OF THIS PAGE N/A	19. SECURITY CLASSIFICATION OF ABSTRACT N/A	20. LIMITATION OF ABSTRACT UL		

A STUDY ON HOW TO IMPLEMENT
AN EFFECTIVE MARKETING AND EDUCATION PROGRAM
FOR COORDINATED CARE

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Major David A. Coker, MS

November 1992

94-13566



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ACKNOWLEDGMENTS

The author gratefully acknowledges the assistance of the Coordinated Care Division, Fitzsimons Army Medical Center and the Marketing & Education Subcommittee of the Gateway to Care Steering Committee. Special thanks to Colonel Sterling Hammond and Major Patrick Shipley for their comments on the draft of the paper and their support throughout my residency.

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Abstract

The Department of Defense is committed to introducing managed care to the military health care system via the Coordinated Care Program. The Army Medical Department has taken the lead in the Department of Defense through the implementation of its Gateway to Care program. These programs represent a radical departure from the military health care system of the past and the manner in which they are implemented may well determine the future of military medicine.

This study describes the process involved in developing a health care marketing plan at Fitzsimons Army Medical Center. It identifies opportunities available to Fitzsimons and provides an action plan to accomplish the established marketing objectives. Upon the completion of the marketing action plan, the process for the approval and monitoring functions is discussed.

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Introduction

Conditions Which Prompted the Study

The Department of Defense is committed to introducing managed care to the military health care system via the Coordinated Care Program. This program represents a radical departure from the traditional manner in which health care has been provided in the past. There can be no doubt that the future of the military health care system will be determined by the performance and success of the Coordinated Care Program.

The Army Medical Department has taken the lead in the Department of Defense through the implementation of its Gateway to Care program. The Commander, U.S. Army Health Services Command has directed that all military treatment facilities will initiate enrollment of beneficiaries not later than July 1, 1992 (Department of the Army, 1992).

Seven essential elements have been identified to focus the efforts of military treatment facility commanders in the development of their local Gateway to

Care programs. Each of these elements is deemed critical to the success of Gateway to Care. They are enrollment, utilization management, outcomes study and management, primary care manager and focus, local design and implementation, specialty treatment facilities and regions of excellence, and marketing and education (Department of the Army, 1992).

The Army Medical Department has not emphasized the use of a marketing perspective in the past.

Identifying marketing as an essential component for Gateway to Care presents an immense challenge to those responsible for the implementation of the program in their local facilities and provides the opportunity to define the future.

Statement of the Management Question

How can an effective marketing and education program be developed that will contribute to the successful implementation of Gateway to Care?

Review of the Literature

Coordinated Care

The Coordinated Care Program is designed to "better accomplish the medical mission by improving

beneficiary access to health care services, controlling health care costs, and ensuring quality care..."

(Department of Defense, 1992, page 1). It is expected that Coordinated Care will reduce the amount of unnecessary utilization of resources through managed care processes, maximize the capacity of military treatment facilities, and encourage commanders to make decisions based primarily on cost-effectiveness.

Managed care processes are those processes used to direct patients to the most efficient providers so that the appropriate medical care can be provided in the most cost-effective setting (Boland, 1991). This represents a fundamental change in the processes used within the Department of Defense to manage its healthcare resources.

Gateway to Care is the Army's coordinated care program in consonance with guidance from the Office of the Assistant Secretary of Defense for Health Affairs. The purpose of Gateway to Care is to develop a coordinated care program that utilizes the lessons learned and experience gained from previous initiatives and demonstrations. The goals of the program are

consistent with Coordinated Care: to control the growth of costs, increase or improve access to the direct care system, coordinate access to cost-effective sources in the civilian community when referral outside the direct care system is required, and to restructure the Army's health care system to encourage use of the direct care system. Components of the program include beneficiary membership/enrollment, designated providers for participants, the use of health care finders for referral/appointment management, utilization management, health information management/analysis, flexible use of CHAMPUS funds, and health services contracting (Department of the Army, 1991).

Major objectives that have been identified include the provision of a comprehensive health care system under the control of a single commander who's responsible for efficient utilization of available resources, maximization of the utilization of the military treatment facilities, expansion of primary care capabilities, improved coordination between military and civilian health care providers, and a reduction in beneficiary reliance on standard CHAMPUS

(Department of the Army, 1991). It is anticipated that all Army medical treatment facilities will have started to implement Gateway to Care by July, 1992.

The office given the responsibility for the implementation of coordinated care initiatives at the local level is the Coordinated Care Division. Guidance from Health Services Command places this division under the direct responsibility of either the Deputy Commander for Clinical Services or the Deputy Commander for Administration. Health Services Command Regulation 10-1, dated 31 March 1989, Organization and Functions Policy states the mission of the division "is to support the MTF commander through a single organizational element to effectively coordinate military and civilian health services throughout the MTF HSR (health services region)".

There have been many initiatives and demonstration projects designed to test the principles behind coordinated care. The earliest test I found documented is the capitation test conducted at Madigan Army Medical Center in fiscal year 1980. This initiative tested the concept of budget capitation utilizing a

regional tri-service decision-making body to reduce health care expenditures for beneficiaries in the Pacific Northwest. Difficulties were experienced during the test because of the lack of fiscal guidance and difficulty in exercising the flexibilities provided to the local commanders for resource allocation (Cahill, 1980). Characteristics of this test that can also be found in coordinated care initiatives are the concept of making the local commander responsible for meeting the needs of his catchment area population, capitation budgeting, and the ability to transfer funds between CHAMPUS and organizational operating funds in order to better meet the needs of the beneficiaries.

More recent initiatives include the CHAMPUS Reform Initiative, Tidewater Mental Health Demonstration, Fort Bragg Mental Health Services Demonstration, CHAMPUS Southeast Fiscal Intermediary PPO, Composite Health Care System, and the Catchment Area Management Demonstration Projects. These are all forerunners of the Gateway to Care program.

Marketing

The concept of marketing is relatively new in health care and especially in the military health care system. John R. Griffith (1987) notes that it was not until the 1980's that hospitals started to recognize the role marketing could play. Philip Kotler and Roberta N. Clarke (1987) recognize that the role marketing plays in health care organizations varies greatly. It is difficult to identify a specific role for marketing because it is such a broad concept and subject to many interpretations.

The definition of marketing accepted by professional marketers is provided by Kotler and Clarke (1987):

Marketing is the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives. It relies heavily on designing the organization's offering in terms of the target markets' needs and desires, and on use of

effective pricing, communication, and distribution to inform, motivate, and service the markets (page 5).

Wendy Leebov (1988) defines marketing as:

A set of organizational practices designed to plan, motivate, and manage the resources and activities of your organization, so that:

- Your organization meets consumer needs and wants.

- The people you want to serve choose your organization for services repeatedly as needed.

- Your organization generates positive opinions of your organization and its services (page 18).

Steven Hillestad and Eric Berkowitz (1991) describe the concept of marketing as:

1. The process of listening to consumers and the marketplace.

2. The philosophy of organizing to satisfy needs of a group or groups of consumers.

3. The satisfaction of these needs in a profitable fashion. (page 51)

While all three definitions have merit, I believe the definition by Hillestad and Berkowitz to be the most compatible with the objectives of Gateway to Care. The Commander, U.S. Army Health Services Command has directed military treatment facilities [MTF] to "design and implement a marketing program designed to target high cost CHAMPUS users who can be accommodated within the MTF system (Department of the Army, 1992, p. 7).

Education

A primary concern, especially among retired beneficiaries, is the erosion of benefits they have earned through service to their country. Opponents of Coordinated Care have attempted to link it to the perceived erosion of benefits and have identified Coordinated Care as the first step towards the erosion of their medical benefits.

We must gain the support of our beneficiaries if Gateway to Care is to be successful. This can only be accomplished through educating and communicating with our beneficiaries. Ronald H. Wohl states that "Communication is the greatest problem facing employers who want to reduce healthcare costs. Why? Because no

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healthcare cost reduction program, no matter how simple or extensive it is, will be effective unless it is successfully communicated to employees" (Boland, 1991, p. 281).

Guidance for the design of the education component is provided in a memorandum from the Assistant Secretary of Defense for Health Affairs. It states:

The Services shall develop and conduct CCP [Coordinated Care Program] training for their hospital commanders/catchment area managers, providers, key staff, and beneficiaries. To assist in the early phases of program implementation, material and presentations should be provided to specific categories of program participants that facilitate enrollment, awareness of benefits, health services access, and economical commitment of program resources (Department of Defense, 1992, page 1).

Generic educational programs must be provided for clinical personnel, administrative personnel, and our beneficiaries. Educational materials that must be developed include a beneficiary handbook, periodic

newsletter for beneficiaries, and literature on health promotion opportunities (Department of Defense, 1992)

Purpose of the Study

The purpose of this study is to identify the opportunities available to Fitzsimons Army Medical Center in the development of the marketing and education component of Gateway to Care and to determine if a marketing approach is applicable to the military health care system. Objectives include reviewing and establishing the mission, conducting internal and external assessments, determining a strategy action match, developing marketing objectives and an action plan, establishing an approval and monitoring process, and upon completion of the marketing plan evaluate the process and its applicability to the military health care system.

Methods and Procedures

Study Design

The study will begin with a review of the mission statement for Fitzsimons Army Medical Center to see if it adequately reflects the transition to Gateway to

Care. Any necessary changes will be proposed to the Executive Committee for their decision.

The next step will be a situational analysis consisting of external and internal assessments. This includes a review of the environment, the market and its needs, the competition, internal capabilities, and the marketing function and programs (Hillestad & Berkowitz, 1991). Data for this analysis will be obtained from available secondary information sources to include the Defense Medical Information System and the Office of Civilian Health and Medical Program of the Uniformed Services. This information provides an assessment of where we are and becomes the foundation for the marketing plan.

After the analysis has been completed, the next step is determining the strategy action match and strategy selection. It is the strategy action match that tells the organization what business to be in and what to do in each business. This provides the organization with a direction of its marketing efforts (Hillestad & Berkowitz, 1991). Once the strategy action match is completed, marketing objectives will be

developed. These objectives need to be consistent with the mission statement and strategy action match.

The marketing objectives will be used to develop marketing action plans. This is a two step process consisting of development and execution. It is important to develop action plans that are realistic. Hillestad and Berkowitz (1991) note that the action plans should address the product/service, pricing, distribution, and communications/promotion.

The final step in developing a marketing plan is the design of the approval and monitoring process. It is important to utilize predetermined criteria to assist the decision-making body in evaluating market proposals. Once a proposal has been approved, its progress must be monitored to determine its effectiveness. This also provides management the opportunity to make any needed modifications during the implementation phase as the deficiencies are noted (Hillestad and Berkowitz, 1991).

Discussion

Review of the Mission

The mission of Fitzsimons Army Medical Center as stated in its strategic plan is "to provide primary and tertiary care for patients, and training for Army Medical Department Personnel, while maintaining a state of readiness for mobilization" (Department of the Army, 1990, p. 1). The strategic plan discusses the mission in terms of its designated components: readiness, sustainment and modernization, regionalization, and education and training. A review of the goals and the established objectives will identify several objectives that are consistent with Gateway to Care (see Table 1). The one issue not addressed in Fitzsimons' strategic plan yet vital to Gateway to Care is cost-containment.

As Gateway to Care evolves at Fitzsimons, its mission and strategic plan must be revised to reflect the new philosophy. A revised mission statement could be "to provide cost-effective primary and tertiary care for patients through Gateway to Care, and training for Army Medical Department personnel, while maintaining a state of readiness for mobilization." Additionally,

Table 1

Goals and Objectives Consistent with Gateway to Care

Goal	Objectives
Readiness	To emphasize the health maintenance and wellness aspects of care.
Sustainment	To assure quality care.
and	To enhance patients' perception of care.
Modernization	To identify projected patient care needs and plan for managed care.
Regionalization	To assist with allocation of resources and requirements within the region. To enhance the patient referral system from the region. To achieve market dominance for available services in the region.
Education and Training	To market Fitzsimons Army Medical Center and its education programs.

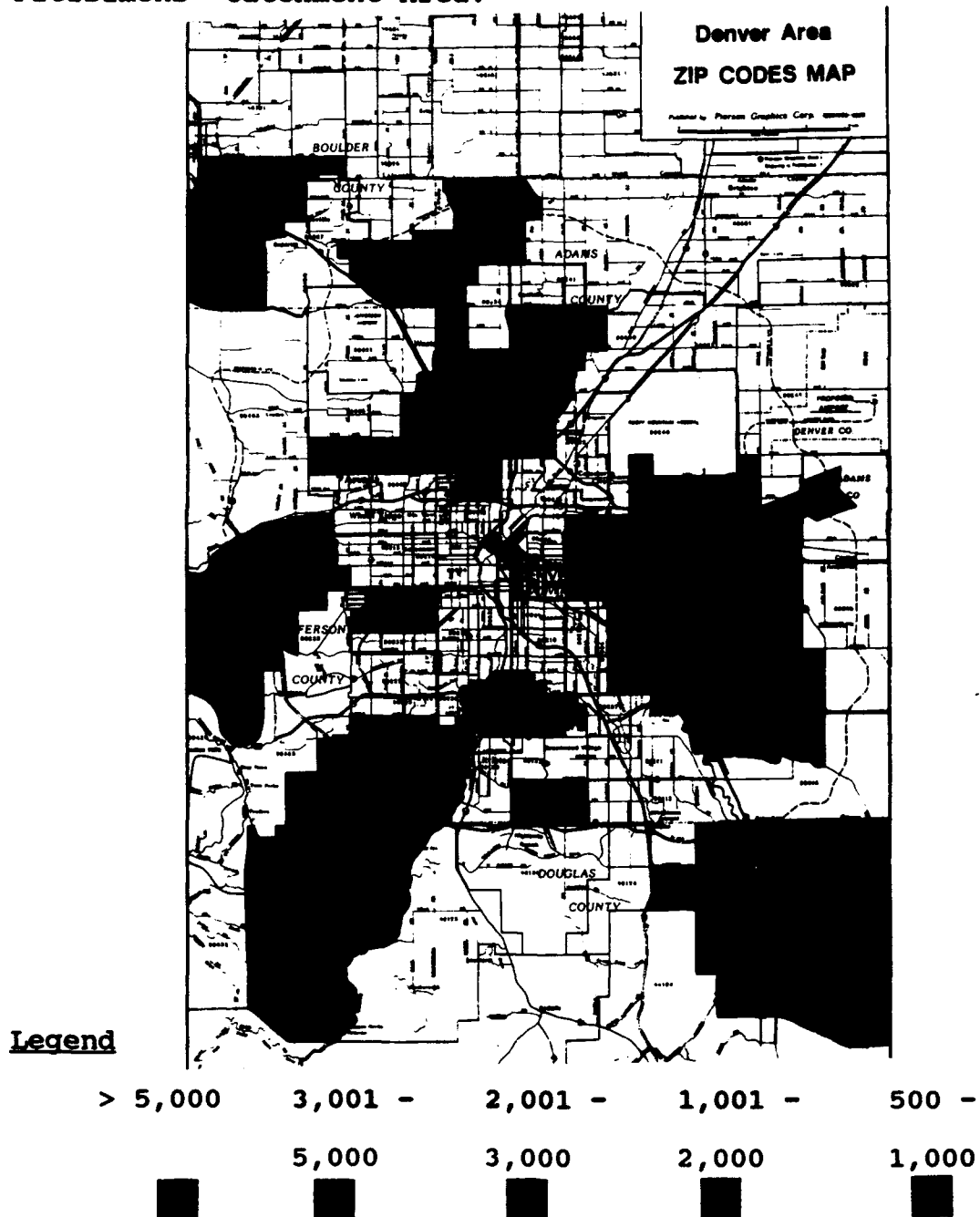
Gateway to Care should be identified as a fifth component of the strategic plan with specific goals and objectives developed.

Situational Analysis

The Environment

The environment in which the Army Medical Department and Fitzsimons Army Medical Center exist is extremely volatile. The Department of Defense recently announced drastic revisions of the Coordinated Care Program at a senior executive conference. These changes were made in an effort to build a consensus of support for the Coordinated Care Program. Other challenges that could still influence the implementation of Coordinated Care and Gateway to Care are the budgetary constraints brought about by the reductions in the size of the Army Medical Department and the lack of reliable data upon which operational decision can be based (United States General Accounting Office, 1992). We are still several months away from being able to implement Gateway to Care as it is designed because of the requirement to publish

Figure 1. Distribution of Beneficiaries in the Fitzsimons' Catchment Area.



regulations authorizing the necessary changes in the military healthcare system.

Market Needs

There are approximately 63,000 eligible beneficiaries living within Fitzsimons' local catchment

Table 2

Fitzsimons Catchment Area Beneficiaries (Fiscal Year 1990)

Male

Age Group	Active Duty	Dep of AD	Retired	Dep of Retired	Other
0 - 17	0	4,392	0	2,038	183
18 - 24	2,549	375	48	1,214	101
25 - 34	2,946	213	224	55	9
35 - 44	1,517	94	1,542	24	9
45 - 64	303	32	9,326	11	11
65 +	0	7	4,708	15	8
Totals	7,314	5,113	15,848	3,357	321

Table 2 (Continued)

Fitzsimons Catchment Area Beneficiaries (Fiscal Year 1990)

Female

Age Group	Active Duty	Dep of AD	Retired	Dep of Retired	Other
0 - 17	0	4,098	0	2,095	200
18 - 24	661	1,748	5	1,416	146
25 - 34	637	2,441	28	379	56
35 - 44	259	1,234	39	1,863	143
45 - 64	27	264	61	7,839	1,087
65 +	0	30	141	2,752	1,361
Totals	1,584	9,815	274	16,344	2,993

Grand

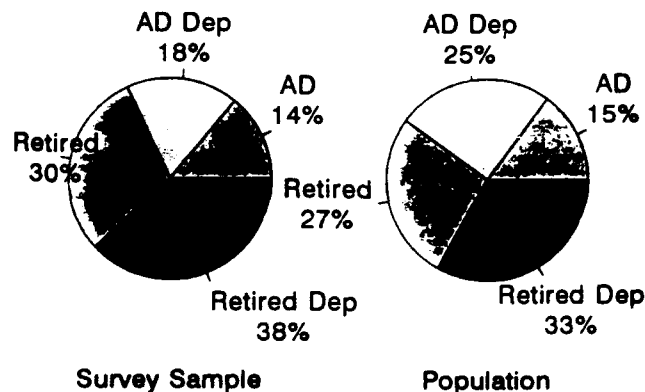
Totals	8,898	14,928	16,122	19,701	3,314
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area (Department of the Army, 1992). The geographical distribution of these beneficiaries is shown in Figure

1. Figure 1 depicts 30 of the 176 zip codes within our catchment area which account for 46,938 beneficiaries or 75 percent of our beneficiary population. Table 2 shows the beneficiary distribution by age and category. 37.8 percent of our beneficiaries are active duty or the dependents of active duty personnel, and 56.9 percent are retired or the dependents of retired personnel. 14.3 percent of our beneficiaries are Medicare eligible.

The Chief of Community Health Nursing at Fitzsimons conducted a Health Care Needs Assessment Survey of 1,006 beneficiaries in anticipation of the transition to Gateway to Care. This survey was adopted from one developed by Kansas State University for the Fort Riley Medical Department Activity (Department of the Army, 1992).

Figure 2. Comparison of the survey sample to the population.



The survey shows that, overall, 26 percent of our beneficiaries have some type of third party insurance coverage. Closer examination reveals that more than 40 percent of retirees and their dependents are insured compared to fewer than 10 percent of the active duty and their dependents (Department of the Army, 1992).

Only 27 percent of our beneficiaries feel that no changes are needed in the Army's health care system. 52 percent believe that only minor changes are needed and 19 percent believe that fundamental change is needed (Department of the Army, 1992). This indicates a attitude among our beneficiaries that would welcome changes to the current system as we transition to Gateway to Care.

In determining what changes need to be made, 81 percent think that it's important to be able to obtain routine medical care in the evenings. 62 percent identified 4:00 pm to 8:00 pm as the most convenient time period for their needs. 78 percent feel that it's important to be able to obtain routine medical care on the weekends. 53 percent overall and 83 percent of active duty dependents said that a Saturday clinic from

8:00 am to noon would be more convenient. Despite the stated desire for changes to our health care system, 91 percent are satisfied with the health care services they have received at Fitzsimons (Department of the Army, 1992).

The Competition

There are 27 hospitals and five psychiatric hospitals located in Fitzsimons' catchment area providing 6,743 beds. The average occupancy for these facilities in 1991 was 64.2 percent leaving excess capacity in the metro Denver area (American Hospital Association, 1991). Fitzsimons primary advantage is that they have a clearly designated, captive beneficiary population that expect to receive free medical care through the military health care system. The Health Care Needs Assessment (Department of the Army, 1992) reports that 86 percent of our beneficiaries feel that it is important to have all medical costs paid for in a health care program.

Internal Assessment

A practical way to measure our ability to compete with local health care organizations is to review our

Table 3

CHAMPUS Costs for the Fitzsimons' Catchment Area
(Fiscal Year 1990)

Medical Specialty	Inpatient Cost	Outpatient Cost	Total Cost
Psychiatry, Group I	\$2,719,697	\$660,743	\$3,380,440
Psychiatry, Group II	2,356,049	591,076	2,947,125
Orthopedics	311,724	701,955	1,013,679
Neurology	170,379	498,714	669,093
Gen Surgery	365,363	303,268	668,631
Cardiology	353,357	219,606	572,963
Pulmonary/Resp	181,357	273,696	455,093
ENT	52,046	371,049	423,095
Gastro	232,368	137,945	370,313
Ob/Gynecology	133,664	86,032	219,676
Others	<u>600,150</u>	<u>938,719</u>	<u>1,538,869</u>
Totals	\$7,476,174	\$4,782,803	\$12,258,977

CHAMPUS costs. Table 3 identifies the CHAMPUS costs for Fitzsimons in fiscal year 1990. Psychiatric expenses total \$6,327,565 or 51.6 percent of our CHAMPUS costs.

OCHAMPUS provides all military facilities with a report of participation statistics for CHAMPUS providers by state. These reports are produced twice a year and are intended to assist the health benefits advisors in locating for beneficiaries those CHAMPUS providers most likely to accept assignment. Tables 4 and 5 provide an analysis of CHAMPUS claims for fiscal year 1991.

Fitzsimons has 56 partnership agreements with 127 providers (Department of the Army, 1992). The top 19 agreements accounted for 18,341 or 45 percent of the 40,720 claims filed in fiscal year 1991 (OCHAMPUS, 1992). It would seem that there is not a great opportunity to recapture CHAMPUS workload outside of psychiatric expenses.

The Marketing Function and Program

There is not a functional marketing element organic to Fitzsimons' organization. The marketing

Table 4

Analysis of CHAMPUS Claims within Fitzsimons' Catchment Area (October 1990 - March 1991)

Specialty	Number of Providers	Number of Claims	Participation Rate
Allergy	2	6	67%
Anesthesiology	8	215	99%
Cardiology	4	28	64%
Dermatology	5	40	30%
ENT	8	62	31%
Gastro	0	0	--
Gen Practice	82	903	85%
Internal Med	21	272	85%
Misc.	69	1,576	81%
Neurology	6	172	95%
Nurses/PA's	7	611	99%
Ob/Gyn	13	889	97%
Ophthalmology	12	36	92%
Orthopedics	8	47	74%
Pediatrics	10	1,374	99%

Table 4 (Continued)

Analysis of CHAMPUS Claims within Fitzsimons' Catchment
Area (October 1990 - March 1991)

Specialty	Number of Providers	Number of Claims	Participation Rate
Psychiatry	93	1,675	95%
Psychology	94	1,002	89%
Radiology	5	786	96%
Surgery	14	283	86%
(Gen, Vas, Thor)			
Surg (Other)	8	371	94%
Other Spec	27	451	90%
Social Work	72	734	89%
Therapists	12	223	97%
Urology	1	3	67%
Clinics	327	11,419	87%
Totals		23,178	89%

Table 5

Analysis of CHAMPUS Claims within Fitzsimons' Catchment Area (April - September 1991)

Specialty	Number of Providers	Number of Claims	Participation Rate
Allergy	1	3	100%
Anesthesiology	14	192	93%
Cardiology	0	0	--
Dermatology	1	14	29%
ENT	5	18	44%
Gastro	3	15	47%
Gen Practice	65	658	83%
Internal Med	20	293	90%
Misc.	61	1,217	85%
Neurology	5	180	91%
Nurses/PA's	6	914	100%
Ob/Gyn	10	679	99%
Ophthalmology	13	34	88%
Orthopedics	4	32	66%
Pediatrics	9	746	99%

Table 5 (Continued)

Analysis of CHAMPUS Claims within Fitzsimons' Catchment Area (April - September 1991)

Specialty	Number of Providers	Number of Claims	Participation Rate
Psychiatry	96	1,436	92%
Psychology	96	888	92%
Radiology	0	0	--
Surgery	12	194	90%
(Gen, Vas, Thor)			
Surg (Other)	2	9	66%
Other Spec	21	334	93%
Social Work	62	370	92%
Therapists	5	150	100%
Urology	1	2	100%
Clinics	353	9,164	85%
Totals		17,542	88%

function is currently performed by a subcommittee of the Gateway to Care Steering Committee. The committee

is chaired by the Public Affairs Officer and membership includes representatives from the medical staff, coordinated care division, clinical support division, and the administrative staff. The committee's efforts have been directed primarily towards the public affairs component of Gateway to Care as that is the forte of the committee chairwoman. As a result Fitzsimons has yet to adopt the marketing concept or to develop a marketing program.

The Strategy Action Match

The strategy action match serves two purposes. It matches an organization's service life cycle with the marketplace life cycle and, based upon that match, it determines the appropriate marketing planning strategy. The four stages in the life cycle model are introduction, growth, maturity, and decline. Hilestad and Berkowitz (1991) note that when a service is being introduced and market demand is beginning an organization may adopt a go-for-it strategy. The possible outcomes for organizations adopting the go-for-it strategy are either success or failure, nothing in the middle.

Product/ Service

The first priority under this strategy is to ensure that high quality is maintained as you introduce your service because early negative experiences will limit the success of the program. It is most important to ensure that you have the capability to meet the demand for services. This is a definite challenge given the constrained resources expected throughout the Army Medical Department in the future.

Price

Organizations tend to use a high price strategy when introducing a service to recoup the high set-up costs of the program (Hillestad & Berkowitz, 1991). Fitzsimons has no latitude in establishing prices as the price structure is established by the Department of Defense. The anticipated price structure for Gateway to Care is shown in Table 6.

Promotion

Fitzsimons should develop a high-profile advertising and public relations profile. We should assume that our beneficiaries know little about Gateway to Care. The first step is to establish a marketplace

Table 6

Anticipated Gateway to Care Price Structure

Feature	CC Plus	CC Extra
Annual Deductible	None	Standard Deductible
Physician Visit	\$ 5	15-20% Cost Share
Lab & X-Ray Svcs	\$ 5	15-20% Cost Share
Routine Pap Smears	\$ 5	15-20% Cost Share
Ambulance Svcs	\$ 5	15-20% Cost Share
Emergency Svcs	\$ 15-25	15-20% Cost Share
Home Health Care	\$ 5	15-20% Cost Share
Family Health Svcs	\$ 5	15-20% Cost Share
Outpt Mental Health	\$ 5-10	15-20% Cost Share
Eye Examination	\$ 5	15% Cost Share
Prescription Drugs	\$ 4-5/Rx	15-20% Cost Share
Ambulatory Surgery	\$ 0-5	0-20% Cost Share
Immunizations	\$ 5	15% Cost Share
Hospitalization		
AD Family	None	None
Ret & Family	\$ 75/Day	\$ 125/Day or 25%

awareness of Gateway and, once a foundation has been laid, to educate beneficiaries about the program.

Distribution

In a go-for-it strategy, it's important to maintain very tight control over the sources of distribution. If the channels of distribution are expanded too quickly it will create management problems (Hilestad & Berkowitz, 1991). The primary distribution channels for Gateway to Care are the Outpatient Clinic, Pediatric Clinic, and the Internal Medicine Clinic. Fitzsimons resources are augmented by a Preferred Provider Network as necessary under the Gateway concept. We should limit the number of providers enrolled in the Preferred Provider Network until we have determined our needs, and then enroll those providers who can best fulfill those needs. We can identify local physicians who are high-frequency CHAMPUS providers through the Participation Report. The high-frequency providers within Fitzsimons catchment are identified in Table 7.

Table 7

High Frequency CHAMPUS Providers (Fiscal Year 1991)

Name	Specialty	Zip Code	No. Claims
Morarka	Pediatrics	80015	2,067
Truppo	Chiropractic	80012	981
Kennedy	Podiatry	80012	544
Reed	Ambulance	80222	365
Nat'l Jewish	Group	80206	337
Rangell	Psychiatry	80218	318
Miller	Neurology	80011	301
Counseling & Consultant Services			
	Group	80012	296
Powers	Orthopedic	80110	264
Peds Radiology	Radiology	80218	232
Harris	Psychology	80012	166
Corkey	Social Work	80012	164
Conceptions Reproductive Technology Consultants			
	Group	80014	137

The Approval and Monitoring Process

The design of the approval and monitoring process is critical in that no organization has the resources to implement every component developed for their business plan. By specifying the criteria that will be utilized to evaluate proposals, an organization is establishing the rules of engagement for everyone in the organization.

Hilestad and Berkowitz (1991) discuss several criteria that can be utilized to evaluate each component of the business plan. One of the most common criteria is an analysis of the return on equity. This is an appropriate measure for Fitzsimons to utilize given the constrained resources the Army Medical Department will have in the future. Other areas that must be addressed during the evaluation process are identified in Table 8.

The components of the Gateway to Care business plan, to include the marketing plan, should be evaluated by the Chief, Coordinated Care Division. Once they have been prioritized, they should be presented to the Gateway to Care Steering Committee for

Table 8

Criteria Used to Evaluate Initiatives in the Approval
and Monitoring Process

Return on Equity

Internal Consistency (with the Strategic Plan)

Consistency with the Environment

Appropriateness in Light of Available Resources

Acceptable Degree of Risk

Appropriate Time Horizon

Workability

their recommendations, with final approval by the Executive Committee. Once the final business plan is approved, it is important to monitor the progress of each of the various components. This would consist of calculating and comparing actual performance in relation to the budgeted plan. It is critical that this information be collected and briefed to both the steering and executive committees.

Conclusions and Recommendations

The first step towards adopting the marketing concept at Fitzsimons Army Medical Center is obtaining command support. The second step is to hire or otherwise designate a marketing director for the organization. The weakest aspect of our marketing program as it currently exists is the lack of information about our beneficiaries. The first priority of the marketing director should be to develop a methodology to build a consumer/beneficiary database. This would involve designing additional survey instruments to refine our data on our beneficiaries. Information needs include verifying existing data, gathering additional demographic data (such as the number of families where both spouses work), statistics on third party insurance coverage and usage, and the identification of high-cost CHAMPUS users.

The marketing director would also be responsible for developing a marketing plan in support of Fitzsimons' regional mission. Just as we must determine the needs of our beneficiaries within our local catchment area in order to meet them, the same

approach should be used to meet the needs of all military treatment facilities within our health services region. This would have the added benefit of facilitating the integration of plans for supporting the local and regional responsibilities under Gateway to Care into a coordinated effort.

The pace with which changes are made in health care and the Army Medical Department will only accelerate in the future. At the same time we will be confronted with a situation where resources are becoming more and more constrained. Fitzsimons Army Medical Center will be better able to meet the demands of our environment by adopting a marketing approach to the organization and specifically the implementation of Gateway to Care.

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APPENDIX A

A Marketing Action Plan for
Fitzsimons Army Medical Center

Overview

Fitzsimons Army Medical Center is committed to Gateway to Care. The purpose of this marketing plan is to assist in the transition to Gateway to Care and a managed care environment. The plan will be completely evaluated at the end of the fiscal year, but can be modified throughout the year as necessary.

Internal/External Analysis Summary

A. The Environment

1. The Coordinated Care Program has recently undergone drastic revisions. We have not yet received authority to implement some of the essential components.

2. The Army Medical Department will be downsized. The effects of the downsizing on Fitzsimons is not known.

3. The FAMC beneficiary population numbers approximately 63,000.

4. Our beneficiary population will decrease as Lowry Air Force Base closes in fiscal year 1994.

5. Fitzsimons Army Medical Center will be considered for closure by the Base Realignment and Closure Committee in fiscal year 1993.

B. Market Needs and Segments.

1. 37.8 percent of our beneficiaries are active duty personnel or their dependents.

2. 56.9 percent of our beneficiaries are retired personnel or their dependents.

3. 14.3 percent of our beneficiaries are Medicare eligible.

4. 26 percent of our beneficiaries have some type of third party insurance.

5. 81 percent of our beneficiaries think it's important to be able to obtain routine medical care in the evenings.

6. 78 percent of our beneficiaries think it's important to be able to obtain routine medical care on the weekends.

C. Competition.

1. There are 27 hospitals and five psychiatric hospitals in metropolitan Denver with an average occupancy of 64.2 percent.

2. 86 percent of our beneficiaries think it's important to have all of their medical costs paid.

D. Internal Assessment.

1. CHAMPUS psychiatric expenses accounted for 51.6 percent of our total CHAMPUS costs.

2. CHAMPUS partnership agreements accounted for more than 45 percent of the remaining CHAMPUS claims.

3. With regard to quality of service, 91 percent of our beneficiaries are satisfied with the health care services they receive at Fitzsimons Army Medical Center.

Strategy Action Match and Strategy Selection

The marketplace in which Fitzsimons is seeking to operate is a new one as we introduce Gateway to Care to our beneficiaries. When a service is being introduced and market demand is beginning, a go-for-it strategy is appropriate. This strategy requires that high quality be ensured as the service is introduced and that

sufficient capability exists to meet the demand for services. This strategy is characterized by a high-profile promotion campaign.

Marketing Objectives.

Objective 1: Increase level of awareness to the extent that 70 percent of our beneficiaries are aware of the Gateway to Care program and its capabilities by the end of fiscal year 1992.

Objective 2: Concentrate our efforts on attracting two segments of our beneficiary population; dependents of active duty personnel and those identified as high-cost CHAMPUS users.

Objective 3: Establish a differential advantage for our beneficiaries (convenience in scheduling, hours of operation and cost avoidance).

Marketing Strategies.

A. Service Strategies.

1. Expand the hours from 0730 to 1930, Monday through Friday, and 0800 to 1200 on Saturdays for all primary care clinics to accommodate the working market.

2. Provide for unscheduled visits after 1700 in the primary care clinics for routine care.

3. Increase the visibility of our staff by providing one seminar per month focusing on health promotion activities and other health issues.

Responsibilities. The Chiefs of each service offering primary care will be responsible for coordinating primary care services. The Chief, Clinical Support Division will be responsible for scheduling of the seminars.

Cost. The costs for this program will be the necessary receptionist/ancillary personnel needed for each primary care clinic. These requirements will be determined by the respective service chief.

Expected Outcome. It is expected that Fitzsimons will be able to establish a clear differential advantage for our beneficiaries through these changes.

Completion Date. All items are to be completed by the end of the third quarter, fiscal year 1993.

B. Promotion Strategies.

1. Develop a beneficiary handbook that explains the Gateway to Care program and specific scheduling procedures.

2. Develop promotional materials for Gateway to Care to be displayed in waiting rooms throughout Fitzsimons.

3. Conduct a quarterly direct mailing to target households regarding availability of services, improvements in services, and health promotion.

Responsibility. The Chief, Coordinated Care Division will be responsible for promotional efforts until a Director of Marketing is hired or otherwise designated.

Cost. The exact costs are to be determined.

Expected Outcome.

a. Achieve 70 percent awareness among beneficiaries for Gateway to Care.

b. Facilitate transition to Gateway to Care.

Completion Dates. Steps 1 and 2 will be completed by the end of the third quarter, fiscal year 1993. Step 3 is ongoing.

C. Pricing Strategies. As determined by the Department of Defense.

D. Distribution Strategy.

The main strategy is to establish new hours of operation in order to develop a differential advantage over the competition.

Organization and Staffing.

A. Organization. All staff members will participate in the implementation of the plan. The Chief, Coordinated Care Division is responsible for the overall plan.

B. Staffing. Staffing will be consistent with the current TDA and the approved Gateway to Care business plan.

Contingency Plan.

If adequate resources are not available to expand primary care services we will look at contracting with established managed care organizations within our catchment area.

Appendix B

HEALTH CARE NEEDS ASSESSMENT SURVEY

Fitzsimons Army Medical Center

SCREENING QUESTIONS: GENERAL

1. STATUS: Please circle appropriate response.

1. Active duty (AD).
2. Dependent, Active duty (D, AD).
3. Retired military (RM).
4. Dependent, Retired military (D, RM).

2. Your closest age category.

1. 18 to 28.
2. 29 to 39.
3. 40 to 50.
4. 51 to 64.
5. 65 or older.

3. Number of children eligible for military health care benefits:

1. One.
2. Two.

3. Three.
4. Four.
5. Five.
6. More than five.
7. No children.

PERSONALLY FUNDED HEALTH CARE

1. During the past year, approximately how many times have you (has your household) gotten medical care which you paid for entirely yourself? (PROMPT: No portion paid for by military health care coverage.)

1. None.
2. 1 to 5.
3. 6 to 10.
4. 11 to 15.
5. More than 15 times.

2. Do you (Does anyone in your household) have some type of non-military health care coverage such as Blue Cross/Blue Shield, Medicare, Medicaid, or a commercial health insurance?

1. Yes.
2. No.

SATISFACTION/EXPERIENCE WITH CURRENT SYSTEM

1. Which of the following statements comes closest to your overall view of the Army health care system?

1. The Army's health care system is fine and no changes are needed.

2. On the whole the Army's health care system works pretty well, and only minor changes are needed to make it work better.

3. There are some good things in the Army health care system, but fundamental changes are needed to make it work better.

4. The Army health care system has so much wrong with it that we need to rebuild it completely.

2. About how many times have you (has your household) received medical treatment at Fitzsimons during the past year?

1. None.

2. 1 to 5.

3. 6 to 10

4. 11 to 15.

5. More than 15.

3. Overall would you say you (your household is) very satisfied, satisfied, dissatisfied, or very dissatisfied with the health care services you have received at Fitzsimons.

1. Very Satisfied.

2. Satisfied.

3. Dissatisfied.

4. Very Dissatisfied.

5. Indifferent (NOTE: Response will not be read).

4. Next I would like to know how satisfied you have (your household has) been with some specific features of the health care service you have received from Fitzsimons. For each of the following please indicate whether you have (your household has) been very satisfied, satisfied, dissatisfied, or very dissatisfied.

The general quality of the medical care received at Fitzsimons. Have you (has your household) been:

1. Very satisfied.

2. Satisfied

3. Dissatisfied

4. Very Dissatisfied

5. Indifferent (NOTE: Response will not be read).

5. The amount of time that physicians at Fitzsimons spend with patients. Have you (has your household) been:

1. Very satisfied.

2. Satisfied

3. Dissatisfied

4. Very Dissatisfied

5. Indifferent (NOTE: Response will not be read).

6. The way in which physicians at Fitzsimons explain your medical problems and treatment to you. Have you (has your household) been:

1. Very satisfied.

2. Satisfied

3. Dissatisfied

4. Very Dissatisfied

5. Indifferent (NOTE: Response will not be read).

GOOD MEDICAL CARE

The next group of questions will provide information to help the Army design its new coordinated health care program. To begin with we would like to know what people think the important features of a health care program are. For each of the following, please indicate whether you feel they are essential, important but not essential, or not important for a health care program.

1. Being able to obtain routine medical care in the evenings. Is this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.
3. Not important.

2. Being able to obtain routine medical care on the weekends. Is this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.

3. Not important.

3. Being able to obtain medical advice by telephone for minor illnesses and minor injuries. Is this essential, important but not essential, or not important for a health care program?

1. Essential.

2. Important but not essential.

3. Not important.

4. Being able to have all medical costs paid for completely. Is this essential, important but not essential, or not important for a health care program?

1. Essential.

2. Important but not essential.

3. Not important.

5. Being able to see the same physician for most of your routine medical problems? Is this essential, important but not essential, or not important for a health care program?

1. Essential.

2. Important but not essential.

3. Not important.

6. Being able to receive most health care services at the same location. Is this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.
3. Not important.

7. Being able to choose your own physician. Is this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.
3. Not important.

8. Being able to get information about what your household can do to keep healthy. Is this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.
3. Not important.

9. Finally, what about having routine health care services located within 30 minutes driving time. Is

this essential, important but not essential, or not important for a health care program?

1. Essential.
2. Important but not essential.
3. Not important.

POSSIBLE GATEWAY CHANGES

Now I would like to get your reactions to several specific changes in health care delivery and health care programs which have been suggested as part of the new Gateway to Care program.

1. One suggestion is that health care facilities should have more flexible hours for providing routine health care. Army facilities and most civilian physicians take appointments from 8:00 to 4:00 Monday through Friday. Are these hours convenient or inconvenient for meeting your (your household's) health care needs?

1. Convenient.
2. Inconvenient (GO TO 2).
3. Indifferent.

2. IF INCONVENIENT TO 1: What if Army facilities for routine health care were open on a 24 hour schedule? Which of the following four hour time periods would be the most convenient for your (your household's) routine medical care needs? (Not Emergency Room Care)

1. 12 midnight to 4 am.
2. 4 am to 8 am.
3. 8 am to 12 noon.
4. 12 noon to 4 pm.
5. 4 pm to 8 pm.
6. 8 pm to 12 midnight.
7. Doesn't matter.
8. Wouldn't use Army facilities regardless.

3. What if Army health care facilities were open from 8 am to noon on Saturdays? Would it be more convenient for you (your household) to obtain routine medical care, or would it not make any difference.

1. More convenient.
2. Would not make any difference.

4. Another suggestion involves having health care professionals provide medical advice over the telephone in the case of a minor illness or minor injury. It is

likely or unlikely that your household would obtain medical advice by phone rather than going to see a doctor in these types of health care situations?

1. Likely
2. Unlikely.

5. Another suggestion involves relying upon alternative health care professionals rather than physicians in routine medical situations. These alternative health care professionals include physician assistants, nurse practitioners, registered nurses, community health nurses, and corpsman/licensed practical nurses. Would you be willing to receive treatment from one of these alternative health care professionals rather than from a physician in the routine treatment situations?

1. Yes.
2. No.

6. A final suggestion which is being considered involves providing more support for mental health and counseling services at Army medical facilities. If your household were to need mental health and

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counseling services, is it likely or unlikely that you would go to an Army clinic to obtain them?

1. Likely.
2. Unlikely.