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MARKETING QUALITY TO CONSUMERS – DOES IT WORK FOR HOSPITAL MARKETERS?

A Thesis
Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Arts in Liberal Arts

in

The Interdepartmental Program in Liberal Arts

by
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B.S., Louisiana State University, 2000

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Abstract

There's no doubt that the emergence of public report cards and governmental requirements for transparency in healthcare are forcing healthcare providers to work vigorously to improve quality and decrease costs. The results of these report cards and rankings are of interest to consumers – who wouldn't want to know whether or not the healthcare provider you're intrusting your life to is *the best.* The lengths to which consumers will go to proactively seek this information is another topic within itself; however, if the information is handed to them through strategic marketing and advertising efforts, could the marketing of quality rating information by individual providers be powerful enough to achieve the ultimate marketing objective: positively shift market share?

A convenience study uses consumer research conducted by individual healthcare organizations across the U.S. to determine if the use of ratings or awards in marketing messages influences consumers' perceptions or preferences of the provider. The findings of this study indicate that advertising ratings or awards can positively impact both benchmarks, but more so perception than preference in terms of the organization overall. However, when considering specific service lines, data indicates marketing of ratings can have a more significant impact on both perception and preference equally. This study revealed the lack of measurement and dedication to ROI by the majority of healthcare marketers.

Chapter 1: Introduction

Healthcare organizations are facing many challenges in the 21st century that are changing today's landscape and molding the future. These organizations are dealing with significant financial issues related to an ever-growing number of uninsured patients and the extensive difference between reimbursement levels and actual expenditures. This has sparked intense competition, igniting a battle for insured customers and the push of profitable service lines. Technology and capital outlay are essential in today's marketplace and the costs to acquire and maintain them are continuously rising. In addition, healthcare organizations are personally responsible for fueling one of the biggest expenditures of all – poor quality. In 2003, Midwest Business Group estimated the annual cost of poor quality among healthcare organizations to be an astonishing $420 billion (Haldeman & Greenwald, 2005).

In 2000, the Institute of Medicine released a report calling attention to the grave disparity among U.S. healthcare providers with regard to quality, which of course, is linked to the ever-increasing cost of healthcare. In his September 2006 report, Michael Leavitt, Secretary of Health and Human Services, declared "every American should have access to a full range of information about the quality and cost of their health care options."

Since 2000, private and governmental agencies have continued to draw attention to this issue, creating report card rating systems and using the national media to keep the topic of healthcare quality in the spotlight. Their efforts, while still in an infancy stage relative to usability are in the very least, forcing providers to improve their quality, and at best, are provoking a new age of healthcare – one in which consumers are no longer

drones who simply follow the instructions of their healthcare providers, but rather inquisitive, demanding, and cost-sensitive users.

While still very much in its infancy, this dawn of consumerism is challenging the many facets of healthcare, including healthcare marketing. Prior to 2000, few healthcare marketers saw consumers as a target audience since managed care and physician preference drove the majority of referrals. But as traditional HMOs fade into the past, managed care options continue to grow, and consumers take hold of their purchasing power, marketers have come to realize the potential for increasing market share through consumer marketing. The question now is: with the dawn of healthcare report cards, are marketers being handed the *golden tool* for positioning and differentiation that, if used properly, could shift market share?

Chapter 2: Marketing Healthcare – A Young Business Practice

2.1 What Is Marketing?

What we refer to today as *marketing* veers much from its original meaning when first introduced in the early 1900s. During this time, marketing consisted solely of sales initiatives without any regard for the full complexity of its current meaning. It wasn't until the 1950s that marketing began to assume the comprehensive meaning it has today. This shift was due much in part to postwar prosperity that left consumers embracing materialism like never before. The concept of "*keeping up with the Jones'* generated demand for a growing range of goods and services" forcing marketers to evolve their roles far beyond that of the traditional salesman (Thomas, 2005).

This revolution called for much more sophisticated strategies of product differentiation, pricing competition, promotional campaigns, and distribution methods. This shift was by no means an overnight event. While it began to take form in the mid-1900s, the evolution of marketing was slow in many respects and is still today considered to be a young and evolving industry.

In 1948, the American Marketing Association (AMA) adopted the definition of marketing from its predecessor, the National Association of Marketing Teachers. This original definition stood until 1985 when it was revised to define marketing as "the process of planning and executing conception, pricing, promotion and distribution of goods, ideas and services to create exchanges that satisfy individual and organizational goals." Nineteen years later, the AMA once again amended the definition, giving us its present form which includes a customer-centered approach with a focus on relationship management. Today's formal definition of marketing, as defined by the AMA, is "an

organizational function and a set of processes for creating, communicating and delivering value to customers and for managing customer relationships in ways that benefit the organization and its stakeholders." As marketing mogul, Kotler, explained, "As an umbrella term, marketing refers to any means of promotion devoted to the ends indicated in the definition" (1975, p. 78).

2.2 Healthcare Providers Slowly Adopt Marketing Functions

Up until the mid-1900s, most "healthcare providers held monopolies or oligopolies in their markets" and were focused on "providing quality care" (Thomas, 2005, p. 10). As part of its responsibility to the community, healthcare providers began communicating with its constituents using public relations (PR) practices. At this time, the industry saw only physicians, donors, and politicos as worthy audiences. They knew they needed to maintain relationships with physicians, as they were the ones referring patients, and they recognized the vital role charitable contributions played in maintaining its non-profit operations. With government expanding its involvement in the healthcare industry, especially where reimbursement was concerned, governmental relations became an essential function for healthcare PR staff. At this time, patients were not seen as a viable audience because they played little part in choosing a healthcare provider (Thomas, 2005).

In 1972, the federal government expanded the list of services reimbursable under Medicare and extended coverage to disabled persons[1]. The 1972 enactment also authorized payments to healthcare maintenance organizations (HMOs) giving way to the increase in the number of HMOs. These changes in Medicare pushed healthcare

[1] In 1965, when Medicare was originally established, it only provided coverage for those over the age of 65.

marketers to deploy sales marketing. With the increase reimbursement opportunities, healthcare providers put a greater emphasis on influencing physician referrals. In an effort to encourage referrals and build physician loyalty, marketers employed sales tactics and incentive programs as part of its marketing strategy (Thomas, 2005).

The increase of HMOs and emergence of for-profit hospitals during the 1970s brought about a new component to the healthcare industry – competition (Thomas, 2005). And in 1977, the American Hospital Association (AHA) hosted its first conference on marketing, pushing organizations to expand their efforts beyond simple public relations activities and incorporate a variety of marketing initiatives.

The 1970s brought about what is likely considered the most significant turning point for healthcare marketers: viewing patients as consumers. This change in perspective added consumers to the list of audiences worthy of marketing efforts and led healthcare marketers to – for the first time – deploy a marketing tactic used by other industries since the mid-1800s: advertising. In an effort to sway patient preference when given a choice by physicians or health plans, the use of print advertising, billboards, television, and radio quickly became common practice for healthcare marketers. This increase in information gave way to a "more informed and demanding consumer," providing marketers an opportunity to add health education materials and special events to its marketing mix (Thomas, 2005).

With employers and consumers emerging as buyers of healthcare services, the focus on physician relations was taking a back seat to consumer-directed marketing. By 1980, healthcare providers "became convinced that they could bring about shifts in market share through marketing initiatives" and invested big dollars to do so (Thomas,

2005, p. 12). Thomas pointed out that in 1983, U.S. hospitals spent $50 million on advertising, and within three years, that figure had risen to $500 million. During this time, healthcare marketing was truly in its infancy. The complexity of the healthcare industry made it virtually impossible to mimic the marketing efforts of other industries, and professionals were left with no precedent, training, or 'how-to' manuals (Thomas, 2005). As Wanless explains, "Healthcare marketing is different than marketing in other industries…[In healthcare], your marketing message must contain an element of mission, goodwill and community service…In other industries, it sounds a bit phony," but in healthcare, it is expected (2005, p. 1).

The "conservative, risk-averse culture of hospitals" left many marketers producing communications that were "ineffectual at best and disastrous at worst" (Thomas, 2005, p. 13).

The inability to measure the effectiveness and value of marketing efforts left many administrators questioning the validity of healthcare marketing. As a result, the late 1980s consisted of the slashing of healthcare marketing budgets and significant decreases in staffing within marketing departments. This shift gave healthcare marketers the opportunity to take a step back to study their field, making research the focus of their existence. It was at this time that the first healthcare marketing textbook was written and healthcare marketing was introduced into collegiate curricula (Thomas, 2005).

As the healthcare marketing field gained tenure, healthcare providers discovered what most marketers have also come to learn – its easier, and less expensive, to retain current customers than it is to gain new customers. This very philosophy brought about

the 1990s guest relations programs in which every hospital was "trying to win the 'hearts and minds' battle for the healthcare consumer" (Thomas, 2005, p. 14).

Following the 1980s marketing budget cuts, healthcare marketers spent a great deal of time studying the marketplace and their various customers while also trying to find ways to measure their efforts. During this time, most marketing efforts were one-way communications with mass audiences. The late 1990s brought about the rise of customer databases, call centers, and websites which emerged as powerful customer relationship management (CRM) tools that engaged consumers (Thomas, 2005).

These new tools gave healthcare marketers the tracking mechanisms needed to justify reclaiming their budgets. This, combined with the increase of resources from the "massive wave of hospital mergers," led to a rise in healthcare marketing budgets once again (Thomas, 2005, p. 15). While there weren't the exorbitant increases that developed so rapidly in the early 1980s, healthcare marketing budgets steadily increased as marketers deployed more strategic efforts and were able to demonstrate return on investment (ROI). However, as healthcare marketers became savvier in winning the hearts of consumers, the rise of the internet spawned a more knowledgeable and empowered consumer than ever before (Wilkins & Navaro, 2001).

These changes in the marketplace gained healthcare marketers a seat at the operations table for the first time. As organizations realized consumerism was an important component of its success and that it had an audience far beyond physicians, donors, and legislators, administrators began to see marketing as part of the hospital's business strategy rather than simply a support department. By the late 1990s, healthcare marketers had evolved their toolbox, letting research guide their marketing efforts which

were now characterized by a comprehensive approach. Integrating all advertising, public relations, promotions, direct mail, interactive media, and CRM efforts brought healthcare marketing to a new level as it approached the 21st century (Thomas, 2005).

2.3 Marketing Healthcare Organizations in the 21st Century

As Vitberg explained, today's "healthcare industry is in a war that will only increase in fervor and intensity as organizations fight for survival and the capture of hundreds of billions of dollars" (1996, p. 4). "From the hospital's perspective," Vitberg contested, "marketing has typically centered around promotion of services… [and] from the physician's perspective, marketing has traditionally been ignored" (1996, p. 13). Today's landscape is greatly changing this outlook, calling all healthcare providers to realize the importance of marketing, bringing about a "renewed emphasis on research, measurement, planning, analysis, forecasting, targeting, segmentation, and strategy" (Thomas, 2005, p. 17).

Competition among healthcare providers continued to increase, especially with the rise of consumer interest and demand outcome data (Vitberg, 1996). This movement is giving way to a variety of changes in healthcare information including the emergence of quality report cards. This need to "build awareness, enhance visibility and image, improve marketing penetration, increase prestige, attract medical staff and employees, serve as an information resource, influence consumer decision making, and offset competitive marketing" will keep healthcare marketers busier than ever (Thomas, 2005, p. 45).

The rise of consumerism in the 21st century has slowly pushed healthcare providers to follow the pharmaceutical industry in its direct-to-consumer (DTC) approach

to marketing. New CRM tools are making this easier than ever, and with the flexibility of today's health plans, consumers are encouraged to take an active role in decisions concerning their healthcare (Thomas, 2005). This shift is forcing "healthcare marketing professionals [to] face the complex challenge of fulfilling a *traditional* role (product development, pricing, packaging, promotion) within an environment of chaos," as organizations are restructured, relationships change, competition increases, pricing is emphasized, quality is recognized, and the power shifts from provider to consumer (Vitberg, 1996, p. 178). Wanting more information than ever, consumers are forcing organizations to provide facts and figures.

The foreseeable future of healthcare will be defined by the active role consumers will play in choosing their providers. As Vitberg reminded us: "the phrase *knowledge is power*, first used by Sir Francis Bacon in 1597, was used in the context of the 16th century view that knowledge is the power through which mankind can create a better life here on earth" (1996, p. 117). It's safe to say that today's consumers are slowly taking Sir Francis Bacon's advice when it comes to healthcare.

Chapter 3: Consumerism in Healthcare

3.1 Patients Become Consumers

"According to just about every healthcare expert, the healthcare industry is witnessing the dawn of a new era – the age of the empowered healthcare consumer" who not only has access to a multitude of healthcare information, but is demanding more (Zuckerman & Coile, 2004, p. 21).

Defined as individuals "who have a want or need for a product," consumers become the center of a marketer's strategy (Thomas, 2005, p. 31). To position their product, marketers identify characteristics unique to their target audience and build all elements – packaging, pricing, advertising, and delivery points – around the preference of their target customers. This technique allows marketers to focus their efforts on those who are most likely to purchase their product and disregard entire sets of consumers who are not potential buyers. This very strategy is what makes healthcare marketing such a unique profession. With federal regulations demanding many healthcare providers to care for all people, regardless of ability to pay, nearly every American is a potential buyer of healthcare services, yet their demand for the service – with the exception of elective procedures – is not driven by *wants* (Thomas, 2005).

But it wasn't until recently that the healthcare industry began to embrace patients as consumers. This shift in perception increased the need for marketing and completely transformed the way healthcare organizations looked at their industry. As patients, people were submissive. They went to the doctors their healthcare plan dictated, followed only the instructions of their physician, and went to specialists and hospitals designated by their physician and/or health plan. But as consumers, people play a much

more active role in their healthcare. They shop and compare health plans, research symptoms and diagnoses, and are sensitive to direct and indirect costs (Thomas, 2005). And why shouldn't they? Consumers arm themselves with information, expert opinions, and statistical data to make informed choices when buying a car, appliances, and other products. It's only natural that they would take the same approach when purchasing something as *vital* as healthcare.

In a 2006 white paper issued by Destiny Health, self-described as an insurance company founded on the concept of putting members in control of their own healthcare dollars, we are reminded of the power of consumers in other industries and their potential impact on healthcare:

> In industry after industry, marketplace after marketplace, knowledgeable consumers have motivated businesses to lower costs, improve quality, and make the purchasing process more convenient. With the needed reforms in place, those good things also can be counted upon to occur within the American health care system. Even better, by putting consumers in the driver's seat, they will prompt many Americans to do what no amount of nagging has been able to accomplish—that is, to adopt healthier lifestyles and smarter spending habits (p. 1).

This "movement toward gaining control of one's health" is primarily being led by baby boomers who are "less trusting of professionals and institutions and are control-oriented to the point of stubbornness" (Thomas, 2005, p. 64). As Kyambalesa explained, today's consumers "expect businesses to provide both high-quality products and low prices simultaneously" (2000, p. 72). Healthcare organizations are not exempt from these demanding standards. This generation is in its prime for consumption of healthcare services yet more resilient, better educated, and more self-reliant than previous generations. With the internet, they have access to information their parents never had,

and they possess a want to be an active participant in their healthcare decisions (Thomas, 2005).

As healthcare consumers continue to increase their participation in choosing providers and methods of care, marketers have shifted from what was once solely a physician-oriented strategy to consumer-oriented marketing. But what should their consumer campaigns say? What information is today's consumer looking for?

3.2 Healthcare Consumers – What Are They Looking For?

As Thomas explained, healthcare consumers "want the outcomes of the healthcare system as patients and the benefits incurred by customers" (2005, p. 89). They "expect to receive adequate information, demand to participate in healthcare decisions that directly affect them, and insist that the healthcare they receive be of the highest possible quality." They also "want to receive their healthcare close to their homes, with minimal disruption to their family life and work schedules," all while maximizing the value and minimizing the cost (p. 65).

Because patients did not play an active role in making healthcare-related decisions prior to today's age of *consumerism*, few meaningful methods for distinction exist, leaving marketers without points of differentiation and consumers basing opinions on "superficial factors such as the appearance of facilities, available amenities, or tastiness of the hospital's food" (Thomas, 2005, p. 34).

Prior to the shift to consumerism, patients saw physicians as their sole source of information. As patients evolved to consumers, they began looking to friends, family, neighbors, and colleagues as information sources. In the 2006 *National Consumer Perception Study* conducted by an independent research firm, Professional Research

Consultants, Inc. (PRC), more than one-third of consumers identified their friends or relatives as their main source of information about physicians and hospitals. When segmented by age, 45 – 54 years of age were most likely to identify friends or relatives as their primary information source, while those 65 and older said physicians are where they get their information.

Today, media is also playing a role as an information provider. While none of the sources have been completely eliminated by the other, they are now “sharing space” in an information-loaded arena dominated by information seekers (Thomas, 2005).

With the shift to consumerism, healthcare marketers quickly began to adopt traditional marketing methodologies, focusing on the 4 P’s – product, place, price, and promotion. For the most part, healthcare providers already had the products consumers needed and wanted. But with increased competition, marketers are being forced to help their organizations take a hard look at the service lines they offer to find a balance in what they have traditionally offered, what today’s consumers are demanding, and which are most cost-efficient to run. The proliferation of specialty centers throughout the country is a result of this very factor.

3.2 Cost as a Point of Differentiation

Historically, traveling to receive service from a distant healthcare provider was not the norm. However, with the flexibility of today’s health plans, most consumers are able to seek healthcare anywhere in the country by simply paying a little bit more. Today’s consumer, who is more affluent and taking greater control over their healthcare, is not only willing to travel, but also able to pay the minimal difference in cost if they feel it will make a significant difference in their outcome. This very shift in the marketplace

has catapulted competition among healthcare providers, leaving every local hospital – in a sense – to compete with the likes of Johns Hopkins Health System, the Mayo Clinic, and M.D. Anderson Cancer Center for specialty services (Zuckerman & Coile, 2004).

In the past, insured consumers have primarily been covered by their employer through managed care organizations. Other than their premium or co-pay, consumers seldom knew the actual cost of the healthcare services they were consuming (Thomas, 2005). But as the cost of healthcare rises and consumers demand higher salaries, employers are becoming more transparent about the dollars they are spending on employee wellness. Many have moved from publicizing only salaries to posting the price of an employees' compensation package which includes dollar equivalents for leave, healthcare coverage, retirement contributions, and other benefits. This strategy is more self-serving for the employer, allowing them to say 'look what we're doing for you.' But it is increasingly becoming an asset to the employee, allowing them to see the hidden costs from which they have historically been sheltered. This, combined with the shift from managed care to healthcare savings account plans and the federal government's requirements for cost transparency, is slowly forcing consumers to *know* what their healthcare services cost – an element that has historically been missing from the healthcare consumer profile. And with the more cost-sensitive, information-seeking personality of today's consumer, price is becoming one element which marketers may be able to use as a point of differentiation (Thomas, 2005).

But price will not prove to be a strong enough distinction within itself. Meaningful product differentiation is almost certainly the most difficult for healthcare providers to demonstrate and without it, promotional strategies fall to nothing more than

simple name recognition (Thomas, 2005). This very problem is what sparked the healthcare advertising wars of the 1980s. Sinking millions of dollars into advertising that hinged on shallow, meaningless messages left marketers regarded as reckless rather than strategic professionals (Zuckerman & Coile, 2004).

Taking into account the history of healthcare and the elevated concerns of rising healthcare costs, it is no wonder organizations are taking a hard look at quality initiatives (Zuckerman & Coile, 2004). Not only are the statistics of patient safety as it relates to quality alarming, but the significant positive correlation between high quality and low costs is quite notable (Lippmann, 2002). In 2003, Midwest Business Group, one of the nation's leading non-profit coalitions of private and public employers, estimated the annual cost of poor quality among healthcare organizations to be an astonishing $420 billion (Haldeman & Greenwald, 2005). This type of impact makes improving quality imperative for the health – and pocketbooks – of our nation.

Chapter 4: Calling Attention to the Quality Gap

According to a working paper published in April 2007 by Hogan & Hartson, LLP for the American Hospital Association (AHA), healthcare providers are "under increasing pressure from others – government and private payers in particular – to improve efficiency and quality" (p. 3). And because HMOs have "created [such] sophisticated buyers [who are] demanding quality outcomes at reasonable prices," healthcare providers essentially have no other option but to follow the demands of the market (Vitberg, 1996, p. 5).

But this is not a revelation. In 2000, the Institute of Medicine (IOM) released the report *To Err is Human: Building a Safer Health System*. This 200-plus page report boldly calls attention to the momentous number of patients who are adversely affected by medical errors, citing that "more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS" (IOM, 2000, p. 26). What is equally astonishing is the notion that "silence surrounds this issue," leaving consumers oblivious to the grave disparity of quality among healthcare organizations (p. 3).

In its report, the IOM admits that there isn't a single solution to the quality issue, but does make many recommendations related to care processes and analysis of events. Its profound title is explained in the simple statement, "to err is human, but errors can be prevented" (2000, p. 5). And while taking steps to prevent these errors will result in safer patient care – our utmost concern – as an added benefit, these efforts will also result in lowing healthcare costs.

Among its many recommendations, the IOM calls for greater transparency and a mandate that healthcare providers make public their cost, quality, and performance data

(2000). While the IOM clearly places full responsibility on healthcare and governmental organizations for ensuring patient safety, the mere publication of this report raises awareness among consumers and inevitably forces them to realize they must become active participants in making healthcare decisions because it could literally be a matter of life or death.

The following year, IOM issued another report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which reinforced the need for quality standards and public reporting insisting that healthcare organizations should provide care that is "evidence-based, patient-centered, and systems-oriented" (2001, p. 20). This 2001 report, unlike its predecessor, identified patients as an active participant in transforming the healthcare system saying they "must become more aware, more participative, and more demanding" when evaluating healthcare providers (p. 20).

4.1 Promoting Quality to the Masses

As a result of the IOM's 2000 release of *To Err is Human* and its 2001 release of *Crossing the Quality Chasm*, a variety of public and private agencies came together in 2002 to form what is now known as the Hospital Quality Alliance (HQA). The alliance is made up of organizations representing consumers, hospitals, doctors and nurses, employers, accrediting organizations, and Federal agencies. The objective of the Alliance, among other things, was to provide the public with "useful, valid, and easily accessible information about hospital quality" (SHSMD, 2005, p. 2). In April 2005, HQA launched its consumer website, Hospital Compare, which featured side-by-side performance comparisons of hospitals across the country. The formation and acceptance of this initiative by a wide array of organizations "was an acknowledgment that the public

expects hospitals to exercise leadership in making more and better information available about the quality of hospital care" (SHSMD, 2005, p. 4).

The nation's most predominant accreditation organization, Joint Commission (formerly known as JCAHO) launched its public comparison website, Quality Check, one year prior to HQA's launch of Hospital Compare. Featuring data on more than 15,000 Joint Commission accredited healthcare organizations, Joint Commission's Quality Check rates institutions using minus signs to indicate performance below the majority of other accredited organizations and check marks to indicate performance similar to the majority of other accredited organizations. Similar to Hospital Compare, Quality Check gives consumers the ability to drill down to actual numbers and percentile rankings related to process data, even though accurate interpretation of this detailed data requires a keen understanding of healthcare reporting and statistical analysis.

In 2005, the Society for Healthcare Strategy and Market Development (SHSMD) released a document to its members on *Communicating Quality: Strategies and Tools for Responding to Public Reporting of Hospital Quality Data*. This document outlined strategies for marketers to use as Joint Commission, HQA, and other organizations promote a consumer culture that demands high quality healthcare. For many healthcare marketers, this was the first real sign that quality could very well become a marketable point of differentiation.

The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services with a mission to improve health care quality and prevent medical errors, produced a *Guide to Quality* in 2005. This consumer guide was designed to help consumers "be active in making decisions about [their] healthcare"

(AHRQ, 2005, p. 1). This *customer empowerment* document calls consumers to differentiate service quality from clinical quality, explaining that while good customer service is important, your health and safety are more essential. This document uses powerful language such as “you deserve…” and “take charge…” and gives consumers advice on what to ask their doctors, how to find and use quality report cards (AHRQ, 2005, p. 16).

In recent years, a multitude of healthcare ratings and awards organizations have surfaced – HealthGrades, Magnet, National Research Corporation (NRC), Solucient, and U.S. News & World Report – just to name a few. All of these organizations work independent of each other and have devised their own, proprietary system of rating the quality of healthcare organizations. Not only do their calculation methods differ, but the characteristics deemed import and worthy of measurement vary from one rating company to another. Within each of their own rite, ratings organizations provide useful data to consumers seeking information regarding quality data; however, consumers face the challenge of not only interpreting the sometimes complex information, but in *reading between the lines* to determine what the data *really* means.

Some organizations, like the American Nurses Credentialing Center (ANCC), focus on evaluating and recognizing superior nursing programs under the belief that nursing is the driving force behind quality care. Rather than the typical rating system, ANCC recognizes superior organizations through an official, highly coveted accreditation. The organizations that adhere to the rigorous standards set forth by ANCC are recognized as Magnet institutions – a designation bestowed on only 4.45% of today’s U.S. healthcare organizations.

In a world where "you can probably get more information about choosing a TV than choosing a doctor or hospital," the Leapfrog group was established to "make reporting health care quality and outcomes a routine feature of the US health care system" (Leapfrog, 2007). Leapfrog is funded by the Business Round Table and its many members representing some of the nation's largest corporations and public agencies responsible for purchasing health benefits on behalf of their employees, dependants, and retirees. Through its website, Leapfrog collects and posts hospital rating information based on a variety of indicators. While the site is accessible to the general public, its target audience is its extremely influential group of members who have agreed to base their purchase of healthcare on principles that encourage quality improvement.

Other companies, such as National Research Corporation (NRC), don't rely on process measures or other hospital-reported data, but rather rank healthcare organizations based on the comments and votes of consumers.

While the former organizations are somewhat unique, the majority of today's ratings companies use data-driven processes with the primary difference between them being their measurement base of outcome- or process-oriented data. Organizations, such as HealthGrades and Solucient, rate healthcare organizations based on risk-adjusted patient outcome data (MEDPAR) and patient discharge information, collected by CMS and other payers. While these two organizations use the same base data, the similarities between them (and the ranking designation of healthcare institutions) end here. Each adds additional factors into their calculations to derive at their ranking assignment for

healthcare organizations across the country, ranking some tops by one rating organization, and bottoms by others (Haldeman & Greenwald, 2005).

Putting less emphasis on outcome data, ratings companies like U.S. News & World Report rate healthcare organizations based on a determined set of reputation and care-related standards such as whether or not it is affiliated with a medical school and if specific technology-related services are available (Haldeman & Greenwald, 2005).

In June 2007, HQA formally recognized the validity of risk-adjusted outcome data by adding mortality rates to its Hospital Compare website. In translating the data, HQA placed hospitals in one of three basic categories: of *better than national rate*, *no different than national rate*, and *worse than national rate*. Of the 4,477 U.S. listed on Hospital Compare, 99.5% of them were rated as *no different than the national rate*, leaving many consumers questioning the value of HQA's newly published data.

While the HQA's most recent attempt to improve public reporting of quality information may have fallen short in its over-simplified categories, the concept of using risk-adjusted mortality rates to evaluate hospitals appears to be a the most reflective measure of quality. According to a 2006 study conducted by two Philadelphia professors, hospital performance and process measures were found to be small, and in some cases trivial, indicators of actual mortality – the pinnacle indicator of healthcare quality. The study suggested Hospital Compare should work to develop "measures that are tightly linked to patient outcomes" (Werner & Bradlow, 2006, p. 2694).

4.2 Slowly, Consumers Are Taking Control of Their Healthcare

In its March 2007 issue, the *Archives of Surgery* featured a study conducted by Dartmouth Medical School and funded by the U.S. Department of Health and Human

Services' Agency for Healthcare Research and Quality (AHRQ). In this study, 500 Medicare patients who had undergone elective high-risk operations within the past three years were surveyed to answer the question, *who picks the hospital*? While 31% of the patients surveyed said their physician was the main decision maker about where they would have surgery, 42% said they played a part in the decision with their physician, and 22% said they were the main decision maker.

The researchers noted that the implications left them questioning if more patients wanted to be involved but weren't "because a paternalistic physician imposed a decision on them" or because they didn't have access to proper information. "In an ideal market, consumers have choice, access, and information…the Internet has created the informed consumer, who has access to [thousands of] health-related web sites for health advice and information (Zuckerman & Coile, 2004, p. 2). According to the Pew Foundation's *Internet and American Life Project* in Washington, DC, more than 120 million Americans are online regularly, and half of them are "health-seekers" who access health information monthly (Fox & Raineie, 2002).

In the 2006 *National Consumer Perception Study*, conducted by Professional Research Consultants, Inc. (PRC), nearly 83% of consumers said they had a preferred hospital. When asked what factors they considered when choosing that hospital, 23% said *good medical care* and *range of service*, while 19% said *reputation* and 18% said *proximity*. Only 7.6% said their doctors' recommendation is what led them to choosing their preferred hospital and 7.2% said insurance dictated this preference.

Solucient, a leader in healthcare performance measurements, released *The Responsive Healthcare Consumer* in 2005. This study found that 63% of responsive

consumers[2] ask their physician to send them to a particular hospital. This number is significantly up from the 37% who reported a willingness to push their physicians to send them to a particular hospital in 2000. But when it comes to truly holding their ground, only 9% of consumers say they would go against their doctor's recommendation if their recommendation was not their preferred hospital. This number has remained consistent since 2000.

These types of studies are merely a glimpse into the shift of roles as consumers begin to take a proactive approach to healthcare decisions, breaking the hold physicians and managed care organizations traditionally had as *gatekeepers.*

4.3 But Are Consumers Using Quality Ratings?

In 2003, Cross, Vice President of the Healthcare Association of New York, wrote an article for SHSMD's newsletter reminding us that "when chest pain strikes in the middle of the night, most consumers are going to call 9-1-1 or head for the nearest hospital emergency room – not run into Junior's room, boot up the PC, and search for *myocardial infarction* on Yahoo!" (p. 7).

While Cross was very accurate, there is much opportunity to continuously educate consumers on *who's the best* prior to needing emergent services. In the 2006 *National Consumer Perception Study*, PRC found only 13.9% of consumers proactively sought out quality ratings on hospitals. Surprisingly, this was down from 25% in 2004 and 28% in 2005. The rise of marketers using ratings within their messages may have impacted this number in the sense that information is now being fed to consumers, which means in

[2] Solucient considers responsive consumers to be those who are likely to respond to marketing of a particular service. Consumers age 30 – 59 dominate this profile.

turn, they no longer have to proactively seek report card data. PRC noted they expect this number to rebound significantly in 2008 with the release of HCAHPS[3] public reporting.

In Solucient's 2005 study, 50% of responsive consumers indicated they have researched hospital and/or physician data one time or another, while only 33% of all other adults have admitted to such actions. In non-emergent situations, 40% of responsive consumers say they are very likely to research quality ratings if they or a family member needs hospital care or surgery, compared to 29% of all other adults. These numbers are significant and noteworthy considering rankings did not exist less than a decade ago.

In Solucient's 2004 study, *The Quality Conscious Consumer*, 58% of all consumers said they would actually change hospitals if their preferred facility received below-average ratings for clinical quality. Surprisingly, only 28% said they would change physicians given the same circumstances.

As early as 1997, researchers learned that 24% of consumers would switch doctors, and 34% would switch hospitals, if they knew they could get better service elsewhere (Sheth & Mittal, 1997). In a 2000 study conducted by VHA, a not-for-profit healthcare provider alliance, 87% of respondents said that a poor or below average clinical quality report would persuade them to choose a different hospital.

According to 2002 data by Endresen Research, 37% of consumers said they are aware of healthcare quality report cards and 20% said they have seen a report card (Cross, 2003). Yet 52% of all respondents said they would consider other hospitals if they had information on quality rankings (HealthGrades, 2002).

[3] Designed by Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), HCAHPS provides a standardized instrument and data collection methodology for measuring patients' perspectives on hospital care.

In a 2002 study by Harris Interactive, a leading online research company, 26% of consumers reported that they had seen rating information on hospitals, with only 10% claiming they've seen quality information on physicians. Harris Interactive took their study one step further, learning that only 3% actually considered changing providers based on this data and a mere 1% took action. Labeling this data as "disappointing," Harris Interactive concluded that "published lists of ratings…have had virtually no impact on consumer choice" (p. 1)

But don't dismiss quality report cards just yet. Harris Interactive's report contended there may be a future impact for quality ratings:

> Just because objective ratings of quality have, as of yet, had almost no influence directly on consumer choice does not mean that they will have no influence in the future. If one looks at other areas where there are regularly published ratings and rankings, such as those published by *Consumer Reports*, *U.S. News & World Report*, or *The Wall Street Journal* (*of Business Schools*), it is likely that they do influence consumers' decisions. Listings that are published every year on a regular basis probably develop a following, or franchise, which means that their influence increases over time (2002, p. 1).

Unfortunately, Harris Interactive has not recently published a replicated study, leaving us to wonder if in fact the paradigm has shifted over the past five years.

Cross is hopeful as she explained that in 2002, Manhattan Research, a healthcare market research and service firm, reported significant increases of visits to hospital websites in which consumers are searching for, among other things, quality data. "Because consumers are predisposed to turn to hospitals for information as well as clinical care," Cross deduced, "the opportunity is clearly there for hospitals to take a lead role in defining what quality is and in promoting their quality" (2003, p. 7). Cleveland Clinic would be a prime example of this.

In August 2003, Cleveland Clinic, one of the largest and most respected hospitals in the country, conducted a study directed it at its *Quality Measures* website viewers which produced different data. Site visitors reported being impressed by the quality data information provided by the Clinic and said it influenced their impression of the organization. Nearly all the respondents believed they would make healthcare decisions differently now that they are aware and know what questions to ask. An impressive 81% said they considered changing hospitals based on quality information, and 61% said they actually did switch providers (Haldeman & Greenwald, 2005).

This study represents a different population than both the Endresen and Harris Interactive study. Those participating in the Cleveland Clinic study either sought out quality data or stumbled upon it when reading up on the Clinic. None the less, the data was statistically valid within its parameters and showed a strong acceptance from those consumers who are exposed to quality information.

As Cross and many other professionals, noted, *defining quality* is something not to be overlooked. Thomas reminded us that because quality is a new concept, many consumers don't know what it is, much less how to evaluate it. Morrison wrote that consumers believe quality is simplistic. "Quality is more (more money, treatments). Quality is having choices. Quality is being in a waiting room with people who earn more money than you do" (2005, p. 78). Clarke reinforced this notion and writes:

> The word *quality* relates to a subjective opinion where meaning is given to the word by the participant. In health care, the definition varies based on the individual or group providing the response…For example, quality to a patient in the health care system is access and timeliness of service; to physicians, it is achieving desirable outcomes; to hospitals, it is financial viability and satisfied customers; to payers, it is the recognition that good quality equates to lower costs and customer satisfaction" (2004, p. 473).

And now, as awareness is generated by the HQA, quality to everyone will be about patient safety and outcomes.

In May 2007, *HealthLeaders* published the most recent research by Thompson Medstat PULSE Healthcare Survey, demonstrating that “consumers are seeking more information about quality and cost than ever before…utilizing resources ranging from advanced Web-based decision tools to casual conversations with friends.” The survey showed that 1 in 5 Americans actively sought information within the past 6 months to help judge the quality of a doctor, hospital or other healthcare provider (Fact File, May 2007). Of those who sought out evaluative healthcare information, more than two-thirds said they were influenced by what they found, with 36.4% of them citing quality data as the driving factor, 27.1% citing credentials and 11% citing pricing and cost (Fact File, March 2007).

The arrival of report cards, 10,000 health-related web sites, and informed consumers signal the end of an era…and the arrival of a new environment for healthcare – consumer choice. (Zuckerman & Coile, 2004)

4.4 Using Quality as a Differentiator

Healthcare is not a tangible product – it’s a service. This means that in healthcare, it’s more about the customer’s experience, the kind service they receive, the type of interaction they have with the provider, they way they feel, and ultimately what their outcome is. Today’s consumer is demanding the best of all of these elements, and while they want it at the lowest cost, they are willing to pay extra for *the best* when necessary (Zuckerman & Coile, 2004).

To determine who is the best in these areas, award and rating organizations have emerged both in the form of private companies, associations, and governmental departments. While some of these groups are following the *Consumer Report* model in that they are collecting data, rating the healthcare organizations, and selling the information consumers, others are offering the data to consumers free of charge. But regardless of their pricing model, all healthcare rating companies are working diligently to tell consumers there *is* a difference among healthcare organizations (Zuckerman & Coile, 2004).

In a 1996 *Journal of Health Care Marketing*, Rapert and Babakus wrote:

> Quality should not be viewed as merely a problem to be solved; rather, it is a competitive opportunity. In an era of increasing competition and potential additional government regulation, a strong quality orientation can serve as the means by which a hospital differentiates itself from its competitors (1996, p. 43).

Cross believed in promoting quality ratings to consumers and that consumers are looking to healthcare organizations to lead them, but admit few organizations take part in "educating the public as to what constitutes quality" (2003, p. 7). She explained that:

> It is important that providers define quality data, offer to provide it, and define themselves as a provider of quality care. The goal of an organization's communications should be to provide information that makes the public better consumers; encourage consumers to ask questions of their providers; inform consumers that data may have limits; and explain what they can do for them (p. 8).

It is true that the rise of healthcare ratings and awards has increased the already competitive nature of the healthcare industry and given marketers another tool to promote their organization. And while some may only see these companies as a marketing ploy, we must not overlook the fact that by their simple existence, these rating companies are raising awareness and forcing healthcare organizations – especially mid-sized, local

providers – to become more efficient and effective, which ultimately results in safer environments, higher quality, better outcomes, and decreased costs (Zuckerman & Coile, 2004).

4.5 Do Quality Ratings Impact Consumer Perceptions, Preferences, and Ultimately Market Share?

Three University of Oregon professors recognized that much research has evaluated the effect of quality ratings in "stimulating hospital quality improvement," but few, if any, have assessed their impact on consumer perception, preference, or market share. In a 2005 *Health Affairs* article, the researchers reviewed the results of their experimental study on the long-term effects of publicly reporting quality ratings (Hibbard, Stockard & Tusler, 2005).

Their experiment used the 2001 Wisconsin Hospital Alliance's public release of *QualityCounts,* a comparative quality report released by the Alliance and purposely formatted in an easy-to-ready, consumer-friendly manner. The Alliance made great strides to ensure the report was widely disseminated using newspapers, direct mail, the internet, printed brochures, and media relations (Hibbard et al., 2005, 1157).

Prior to the release of the report, the researchers gathered baseline data on the current perceptions, preference and market share of the hospitals included in the report. In the two years following the release of *QualityCounts*, they polled consumers to determine its long-term effects. Immediately following the report's release:

> Only 4% of consumers exposed to the report used it to recommend or choose a hospital and only 10% reported having done so in the 2 years after its release. However, 24% had talked to others about the report in the immediate post-period and almost half had talked to others in the next 2 years. Almost no one spoke with their doctor about it (Hibbard et al., 2005, p. 1157).

In addition, the researchers found that more than 30% of consumers exposed to the report correctly identified highly rated hospitals. Yet "recall of poorly performing hospitals was better than recall of high performers," exceeding 40% (Hibbard et al., 2005, p. 1157).

The experiment showed that "consumers exposed to public [quality] reports are much more likely than others to have accurate perceptions of the relative quality of local hospitals, and these perceptions persisted for at least 2 years after the release of the report" (Hibbard et al., 2005, p. 1157). The researchers used discharge data to evaluate market share, but found no significant changes within the 2 years following the release of the report.

The researchers noted that *QualityCounts*, unlike most other public quality reports, was designed in an easy-to-read format and widely disseminated. These particular attributes can led such reports to "have a powerful effect on [the] reputation" of the intuitions rated within the report (Hibbard et al., 2005, p. 1159).

Studies such as these have not been widely replicated, leaving marketers continuously asking the question of whether quality ratings affect consumer perception, preference, and market share. For this very reason, the focus of this thesis lies in the quantitative study of data reported by healthcare marketers in an online survey regarding their use of healthcare ratings in marketing initiatives and the impact they have seen in their organizations.

Chapter 5: An Exploratory Study

Most, if not all, agree that "quality orientation is a viable competitive weapon that should assume a strategic role within [healthcare] organizations (Rapert & Babakus, 1996, p. 39)." Not only do the efforts result in better outcomes for patients, but high quality healthcare results more efficient operations and lower costs.

While this has been a much talked about topic among providers, payers, and regulatory agencies, consumers have paid much less – if any – attention to the matter (Rapert & Babakus, 1996). This is, in part, because of the historical culture in which consumers trusted that they were receiving the best possible care. Consumers have traditionally played a silent role in their healthcare decisions and blindly followed the direction of their insurer or physician. With the rise of the information-hungry consumer, the aggressiveness of baby boomers, and the all-access portal provided by the Internet, healthcare is witnessing the dawn of consumerism.

Knowing that consumers are not quality-savvy, nor are an overwhelming majority taking an active role in choosing their provider, is it beneficial for marketers to use quality ratings or awards in their marketing messages? This exploratory study seeks to answer this question both in a quantitative and qualitative manner.

5.1 Sample

The Society for Healthcare Strategy and Market Development (SHSMD) is the premier organization for healthcare professionals responsible for communication efforts such as marketing, public relations, governmental affairs, sales, and business

development. SHSMD, boasting nearly 4,000 members, is an affiliate organization of the American Hospital Association.

Every fall, SHSMD sponsors an educational conference. The 2006 conference was held September 6–8 in Phoenix, Arizona. While the entire SHSMD membership list was not publicly available, a list of its 1,039 2006 conference attendees was obtained to form the base sample population for this study. The list was then mined using the following systematic approach:

1. Of the 1,039 listed attendees, 918 denoted an email address on their registration information.
2. Two of the listed attendees were representatives from ratings companies identified in the survey – HealthGrades & Solucient. To avoid conflict of interest, these two attendees were removed from the sample population.
3. In instances where an organization had sent multiple representatives, the individual most likely to be responsible for advertising and market research remained part of the sample while the others were purged to ensure each organization only received one survey request. For example, if the CEO, Director of Business Development, and VP of Marketing of a single organization were all conference attendees, the VP of Marketing was chosen to be part of the sample while the others were purged from the population.

Following the above edits to the base sample population, 653 names with email addresses were identified as the sample population, representing organizations located in each of the 50 U.S. states.

The electronic survey was launched on May 21, 2007, inviting the 653 members of the sample population to participate. Following the launch of the survey, the sample size was further reduced due to the below:

1. Ten of the 653 invitees were found to have invalid email addresses and were not reached.
2. Six additional invitees selected to opt-out of the survey for reasons unknown.
3. Via email, four invitees requested to be removed from the list citing lack to time or interest in completing the survey or it being not applicable to their current job responsibilities.

After purging these additional invitees from the population, the accessible sample size included 633 members.

5.2 Methodology

An online survey was developed using Dillman's Tailored Design procedures as the measurement instrument. The Tailored Design approached is centered on creating "respondent trust and perceptions of increased rewards and reduced costs for being a respondent, which take into account features of the survey situation and have as their goal the overall reduction of survey error" (2007, p. 27).

In an effort to encourage response, Dillman's guidelines for social exchange were followed throughout the survey process. The email invitation sent to the sample population requesting their participation incorporated a sense of common interests, confirmation of legitimate authority, social validation, minimal time requirement, ability to remain anonymous, a reward offering, and a sincere sense appreciation (see Appendix A for invitation text).

A 26-question survey was designed to help answer the study question: is it beneficial for marketers to use quality ratings or awards in their marketing messages? Within the 26 questions, 7 of the questions assessed the type of organization the respondents represented, 4 questions sought to determine the type of rating systems or awards with which the respondents have experience, 8 of the questions related to outcomes of marketing campaigns involving rating or award messages, and the final 7 questions established baseline demographics about the respondents.

Dillman encouraged the use of mixed, but appropriate, answer functions to reduce survey exhaustion and keep participants engaged. For web-based surveys, Dillman suggested using radio buttons for questions that allow only one answer, checkboxes for questions that involve selecting multiple answers, drop-down boxes for intuitive, sequential lists, and text boxes for open-ended questions (2007). These guidelines were followed for optimal survey design.

To get participants comfortable, the simple, straight-forward questions assessing the type of organization the respondents represent were placed at the beginning, as suggested by Dillman (2007). Quick demographic questions were placed at the end, allowing the core research questions to be the center and focus of the survey (see Appendix B for survey questions).

Prior to launching the survey to the sample population, it was pre-tested by a select group. The pilot survey was successfully emailed to 12 healthcare marketing professionals matching the demographics of the base population, but not in attendance at the 2006 SHSMD conference. As a result of the pilot, one change was made to the survey. Few questions were made mandatory, as encouraged by Dillman (2007).

However, in the pilot survey, the first question on Survey Page 2 was left unanswered by one participant. After reviewing the overall data from the pilot, response to this question was deemed vital so it was revised to be a mandatory question in the final survey.

5.2 Results

The survey invitation was successfully emailed to 633 recipients on Monday, May 21, 2007. The survey remained active for 30 days, closing on Tuesday, June 19, 2007. In addition to the initial email invitation, three email reminders were sent during the 30 day period to those who had not yet responded at the time of the reminder.

Useable surveys were received from 86 respondents, resulting in a 13.59% response rate. Eighty-four percent of the respondents (*n=71*) were hospitals or health systems, with 89% of the hospitals (*n=65*) being not-for-profit organizations. Nearly half of all respondents (*n=40*) represented facilities with 400-plus patient beds and 63% of those respondents (*n=25*) currently manage 6 or more locations. Twenty-four percent (*n=20*) represented single-location facilities, most with 200-400 beds (see Table 1).

Table 1: Number of Patient Beds as it Relates to Number of Hospital Locations

	Total*	0 – 50 beds	51 – 100 beds	101 – 200 beds	201 – 400 beds	401 beds or more	Not applicable
	83	1	4	11	16	40	11
1 location	20 24.10%	0 0.00%	2 50.00%	3 27.30%	8 50.00%	3 7.50%	4 36.40%
2 – 3 locations	11 13.30%	0 0.00%	2 50.00%	1 9.10%	2 12.50%	6 15.00%	0 0.00%
4 – 5 locations	14 16.90%	1 100.00%	0 0.00%	4 36.40%	2 12.50%	6 15.00%	1 9.10%
6 or more locations	38 45.80%	0 0.00%	0 0.00%	3 27.30%	4 25.00%	25 62.50%	6 54.50%

Respondents were fairly evenly dispersed across the country, representing 37 different states, with the largest concentration of respondents located in Texas, Ohio, Indiana, and Florida (see Table 2). Nearly half of the respondents reported a marketing budget of $1 million-plus (*n=40*).

Table 2: Number of Responses from SHSMD Members by U.S. State

State	# of Responses	% of Total Responses
AZ	1	1%
AR	1	1%
CA	3	3%
CO	3	3%
CT	1	1%
DE	2	2%
FL	5	6%
GA	1	1%
ID	1	1%
IL	4	5%
IN	6	7%
KS	1	1%
KY	1	1%
LA	2	2%
MD	3	3%
MA	1	1%
MI	3	3%
MN	1	1%
MO	4	5%
MT	1	1%
NE	1	1%
NJ	2	2%
NM	1	1%
NY	2	2%
NC	3	3%
ND	1	1%
OH	7	8%
OR	3	3%
PA	1	1%
SC	2	2%
TN	2	2%
TX	8	9%
VA	3	3%
WA	2	2%
WV	1	1%
WI	2	2%

NOTE: States highlighted in yellow represent highest number of responses (*n=86*).

As it relates to the individual respondents, 81% (*n=69*) defined their primary function as marketing and/or public relations. Sixty-five percent (*n=55*) said they recommend decisions to a supervisor or board who has final approval and 29% (*n=25*) said they are the final decision maker when it comes to using healthcare ratings in marketing messages.

Seventy-one percent of the respondents (*n=60*) were female, with 43% (*n=36*) of the total respondents falling between the ages of 45-54 and 29% (*n=24*) between the ages

of 35-44. Ninety-eight percent (*n=82*) of the respondents identified themselves as being of the Caucasian/White race. Half of the total respondents have been with their current organization for less than 5 years (*n=43*); however, 48% (*n=41*) have been in the healthcare marketing industry for 16 years or more and 36% (*n=31*) have been in the field 6-15 years.

Eighty-one percent (*n=70*) reported using ratings or awards in their advertising within the past five years with most using Solucient, HealthGrades, U.S. News & World Report, and Magnet (see Table 3).

Table 3: Ratings/Awards Respondents Have Used in Marketing Messages within the Past 5 Years

Rating/Award	# of Responses	% of Total Responses
Solucient	33	23%
HealthGrades	23	16%
U.S. News & World Report	22	15%
Magnet	20	14%
National Research Corporation (NRC)	11	8%
CMS/JCAHO	4	3%
Press Ganey	4	3%
Local Awards	6	4%
Child Magazine	3	2%
Modern Healthcare	3	2%
Most Wired	3	2%

Rating/Award	# of Responses	% of Total Responses
Professional Research Consultants (PRC)	3	2%
JD Power	2	1%
Commission on Cancer	1	1%
Fortune 100 Top Employer	1	1%
Institute for Healthcare Improvement Mentors	1	1%
Leapfrog	1	1%
Money Magazine	1	1%
Premier	1	1%
State of the Hospital Industry	1	1%
Working Mother	1	1%

NOTE: (*n=145*)

Of the 19% (*n=16*) who reported not using ratings or awards in their advertising, 38% (*n=6*) have considered using HealthGrades, one of the nation's leading independent healthcare ratings organizations (see Table 4).

Table 4: Ratings/Awards Respondents Have Considered Using within the Past 5 Years

Rating/Award	# of Responses	% of Total Responses
HealthGrades	6	27.27%
Solucient	3	13.64%
U.S. News & World Report	3	13.64%
Child Magazine	2	9.09%
Magnet	2	9.09%
Forbes 100 Best Places To Work	1	4.55%
J.D. Powers	1	4.55%
National Committee for Quality Alliance (NCQA)	1	4.55%
National Research Corporation (NRC)	1	4.55%
Nursing Home Quality Initiative (NHQI)	1	4.55%
Various Local Awards	1	4.55%

NOTE: Only respondents who have not used ratings/awards within their marketing messages are included here (*n=22*).

When asked their reason for not using ratings within their marketing messages, responses included such comments as:

- Consumers don't understand ratings, so why use them.
- We do not want/can't afford to pay for usage of ratings.
- Ratings aren't available our specific service line.

- We don't believe publicizing ratings will achieve the marketing goals of our organization.
- It's our organization's policy not to use ratings within marketing messages.
- Our competitors are rated higher than us.

None of the respondents listed lack of receiving high ratings or awards as their reason for not using them.

Seventy-one percent of the respondents (*n=50*) who reported using ratings in their advertising do not have data evaluating their marketing efforts. Those who have measured their efforts do report having 6 or more years experience in healthcare marketing (see Table 5).

Table 5: Number of Years Experience Respondents have in Healthcare Marketing as it Relates to Having Data that Evaluates their Marketing Efforts Involving Ratings/Award Messages

		Total*	**Use ratings/ awards in marketing campaign, but DO NOT have data evaluating these efforts**	**Use ratings/ awards in marketing campaign and DO have data evaluating these efforts**
		70	50	20
How long have you been in the healthcare marketing field?	Less than 5 years	12 17.10%	12 24.00%	0 0.00%
	6 – 15 years	21 30.00%	13 26.00%	8 53.77%
	16 or more years	36 51.40%	24 48.00%	12 46.23%
	Not in the healthcare marketing field	1 1.40%	1 2.00%	0 0.00%

NOTE: (*n=70)*

Of the 28% (*n=20*) who had data evaluating their marketing efforts, most reported using the evaluative benchmarks requested in this survey. Thirty-five percent (*n=7*) were using base data from 2000 or prior and 53% (*n=10*) were comparing against data collected in 2006 (see Table 6).

Table 6: Data Collection by Respondents Using Ratings/Awards within Marketing Messages and Reporting Data

Initial Benchmark Data Collected (*n=20*)		
2000 or Prior	7	35%
2001	1	5%
2002	0	0%
2003	3	15%
2004	3	15%
2005	6	30%
2006	0	0%

Most Recent Comparison Data Collected (*n=19*)		
2000 or Prior	1	5%
2001	0	0%
2002	0	0%
2003	1	5%
2004	1	5%
2005	1	5%
2006	10	53%
2007	5	26%

Seventeen respondents said they measured the percent-change in overall perception of their organization's reputation and 41% of those (*n=7*) saw an increase among consumers of less than a 5%, while 24% (*n=4*) saw a 6-10% increase, 12% (*n=2*) saw an 11-20% increase, 5.8% (*n=1*) reported an increase greater than 21%, and 18% (*n=3*) reported that perception remained constant.

Just over half of those reporting data on consumer preference (*n=17*) saw a 5% change in consumers' preference for their organization following their campaign, while 18% (*n=3*) found preference remained constant. Twelve percent (*n=2*) reported a 6-10% increase in preference for their organization while another 12% (*n=2*) reported an 11-

20% increase. Like overall perception, 5.8% (*n=1*) reported an increase in preference greater than 21%.

Regarding specific service lines or attributes promoted, 31% (*n=4*) reported an increase in perception below 5%, while 39% (*n=5*) reported an increase of 6-10%, and 15% (*n=2*) saw an increase of 11-20%. Eight percent (*n=1*) reported an increase greater than 21%, while another 8% reported perception for a specific service line remained constant.

Data for increase in preference of a specific service line was similar. Thirty-six percent (*n=4*) reported an increase in preference below 5%, another 36% (*n=4*) reported an increase of 6-10%, 18% (*n=2*) saw an increase of 11-20%, and 9% (*n=1*) reported that preference remained constant.

Just over half of the respondents reporting recall data (*n=6*) said that 11-20% of consumers recalled the campaign featuring rating or award messages, while 18% (*n=2*) reported that less than 10% recalled their campaign. Another 18% (*n=2*) reported 51-71% of consumers recalled their campaign and 9% (*n=1*) reported that 36-50% recalled theirs.

5.3 Discussion of Findings

With the increasing quality standards of Joint Commission and the ongoing mandates of the federal government to make hospital quality data publicly available, there is no question that hospitals are focusing more on improving processes that affect their quality of care and patient outcomes. The purpose of this study was to determine whether or not quality ratings are useful to healthcare marketers. In other words, could the marketing of quality ratings by individual healthcare providers be powerful enough to

affect the two golden benchmark variables needed to shift market share: consumer preference and perception?

Due to financial and time limitations, this study was constructed to compile consumer research data collected by individual healthcare organizations across the U.S. The usable responses from this survey indicated advertising quality ratings or awards can positively impact both benchmarks, but more so perception than preference in terms of an organization's overall reputation. The 2005 finding by the University of Oregon that consumer perceptions of healthcare organizations can be altered by exposure to quality data is substantiated by this study (Hibbard et al., 2005). However, with few organizations reporting major shifts in preference, Solucient's 2004 study showing that 58% of consumers would actually change hospitals if their preferred facility received below-average ratings for clinical quality, is not supported here. Harris Interactive's 2002 data, which showed only 3% of consumers considered changing providers based on quality data and 1% actually took action, is more comparable to the data revealed in this study. Yet, based on this study and the compilation of secondary research presented here, one could reasonably argue that Harris Interactive's conclusion that "ratings…have had virtually no impact on consumer choice" is inaccurate, or at the least, not predictive of today's landscape, or the coming years (2004, p. 1). In fact, the very same report issued by Harris Interactive reminds us that the "influence [of product/service ratings] increases over time" – explaining the slow, gradual shift in the effects on consumers (p. 4).

According to Dillman's formula, a population size of 4,000 (number of total SHSMD members) requires 94 completed surveys to achieve a ±10% sampling error with a 95% confidence level (2007). This calculation assumes a 50/50 split of the sample

population since demographics of SHSMD members widely vary (organization size, type, budget, etc.). With 86 responses, the sampling error for this study is ±10.45% and the confidence level is 93.8%.

SHSMD members, while predominately employed by hospitals, also consist of ambulatory care providers, long term care providers, physician groups, independent consultants, and other types of healthcare-related professionals. The majority population – consisting of hospital marketers – within SHSMD is reflected in this study, with 81% (*n=68*) of the total respondents being mid- to large-sized hospitals (101-plus beds) and nearly half of the total respondents (*n=40*) working with a marketing budget of $1 million or more. Contrary to popular belief that for-profit organizations have larger marketing budgets, only 25% of for-profit hospital respondents reported a marketing budget greater than $1 million, while 51% of not-for-profit hospital respondents reported marketing budgets exceeding $1 million (see Table 7). However, the disproportion of respondents in the two categories must be noted here – only 4 for-profit hospitals responded to this question, compared to 65 not-for-profits who responded.

The use of ratings or awards within marketing messages appears to be a common practice for the healthcare marketers surveyed, in particular, those possessing sizable budgets of $1 million or more (see Figure 1). This finding does not represent volume of advertising, but rather the willingness to utilize ratings within marketing messages. This may be a result of organizations with larger budgets having greater abilities to explore the use of contemporary strategies, while others with lower budgets are more comfortable sticking to traditional marketing strategies that have proven to be successful and are viewed as *safe* or proven. This is not surprising since organizations with higher budgets

tend to be early adopters, while those with less capital are predominately late adopters. If consumers continue to stand up and take notice, and the promotion of quality continues to help marketers increase perception and preference, it is likely that those with lower budgets will shift to this strategy once they have gained confidence in its effectiveness.

Table 7: External Marketing/Communications Budget (Excluding Salaries) as it Relates to Hospital's Profit Status

	Total*	Less than $75,000	$75,001 - $200,000	$200,001 - $600,000	$600,001 - $999,999	$1 million or more
	71	0	2	15	17	35
For-profit	4 5.60%	0 0.00%	0 0.00%	1 25.00%	2 50.00%	1 25.00%
Not-for-profit	65 91.50%	0 0.00%	2 3.08%	13 20.00%	15 23.08%	33 50.77%
Other	2 2.80%	0 0.00%	0 0.00%	1 50.00%	0 0.00%	1 50.00%

NOTE: Includes respondents from hospitals only (*n=71*).

But in today's marketplace, where demonstrating return on investment (ROI) is becoming increasingly important to healthcare marketers, it is surprising that nearly three-fourths of the healthcare marketers who responded did not have data evaluating their concentrated marketing efforts. This finding presents limitations for this study, but even more importantly it depicts an industry-wide challenge. As healthcare technology becomes a higher, more frequently recurring cost, reimbursement levels decrease, and competition for patients increase, it is only natural that healthcare marketers will see their budgets cut (or positions replaced) if they are unable to provide ROI-focused administrators with numbers that demonstrate worth, effectiveness, and the impact of

marketing on the bottom line. As Thomas pointed out, today's landscape requires an "emphasis on research, measurement, planning, analysis, forecasting, targeting, segmentation, and strategy" (2005, p. 17).

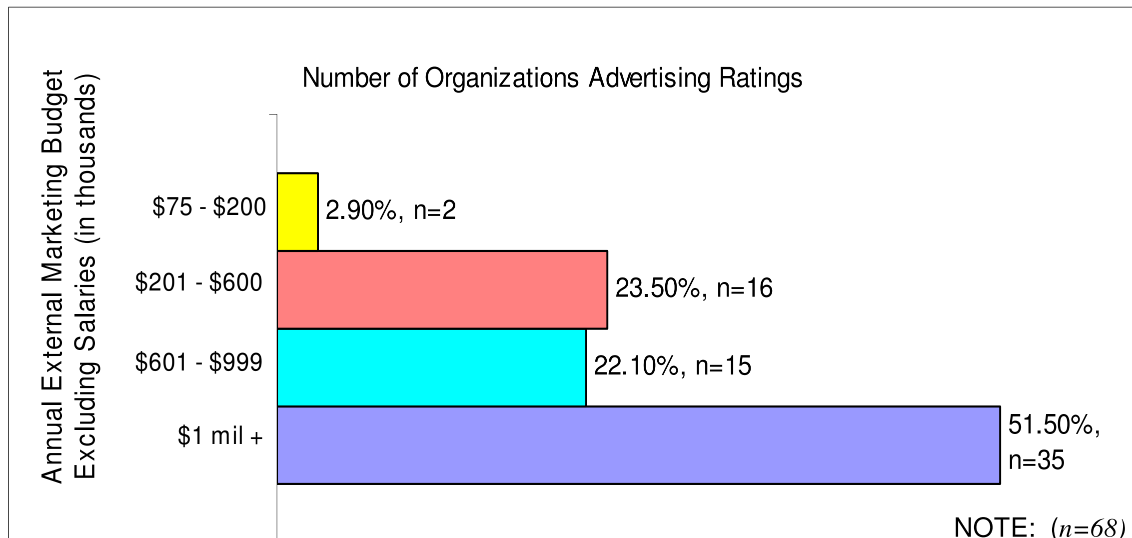

Figure 1: Annual External Marketing Budget of Respondents Promoting Quality Ratings

While only 23% (*n=20*) of participants reported data evaluating their marketing efforts, all were hospital marketers who have found that when rating promotions do impact consumers, it is positive (see Figure 2). This very notion doesn't negate Cross' 2003 statement that "when chest pain strikes in the middle of the night, most consumers [will]…not run into Junior's room, boot up the PC, and search for *myocardial infarction* on Yahoo!" (p. 7); however, with proper messaging and marketing, there would be no need for consumers to consult Yahoo! Rather, they would be well aware of which hospital is *the best* overall, or in a particular service line, from television commercials, direct mail pieces, billboards, print ads, word of mouth, or from other means.

Because of its limitations, this study did not explore the creative implementation, medium, or frequency used by these marketers, but there is no denying that these factors do contribute to the effectiveness of any marketing campaign, regardless of the message content. For those reporting no change (shown as *remained constant* in forthcoming figures), these unknown variables may explain their lack of effectiveness. None of the participants reported a decrease in perceptions or preferences when promoting ratings, demonstrating there is little risk – as related to these measures – associated with using ratings within marketing messages.

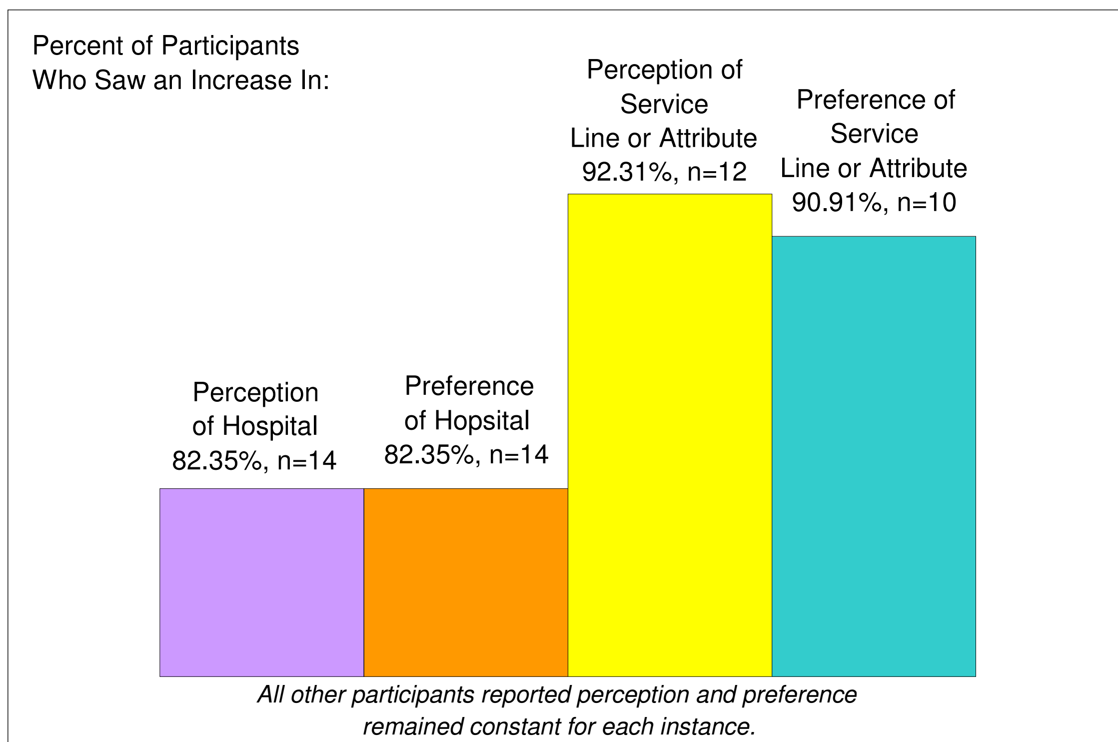

Figure 2: Number of Organizations Promoting Ratings that Have Experienced Positive Impacts on Perception and Preference

The hospital marketers reporting data show a greater impact on both consumer perception and preference for specific service lines/attributes promoted with

ratings/awards. Oddly enough, this influence doesn't always equally impact perception and preference for the hospital overall – at least not simultaneously. However, one could reasonably predict that as perception and preference increase for a particular service line, over time, the image and usage of the hospital overall would follow a similar trend line. In other words, the increase in prestige and demand for a particular service line (i e: cardiology services) is likely have a positive impact on the hospital overall, resulting in a positive perception of the hospital as a whole and gradual increase in demand for its other services.

For nearly half of the hospitals reporting data, the level of increase in perception and preference overall appears to be small – less than 5% (see Figures 3 and 4); however, when consolidating the groups who saw a 6% increase or more in change in perception, the values were equal with 41.2% (*n=7*) reporting less than 5% increase and 41.2% (*n=7*) reporting a 6%-plus increase. For overall preference, 29.4% (*n=5*) experienced a 6%-plus increase compared to the 52.94% (*n=9*) who only saw a 5% increase.

This very phenomenon demonstrates the ability for marketers to effectively alter consumer perception, but not necessarily have equal impact on preference. Marketers measure perception because they know they must first alter consumer opinion before they can convince the consumer to *buy*. Once these two stages are conquered, a marketer's next task is to instill loyalty. In healthcare, this process of *capturing* the consumer is made a little more complex because of the overall uniqueness of the healthcare industry, compounded by the dictations of insurance providers. Unlike other consumer products and services, healthcare – with the exception of elective services – is not driven by *wants*. Rather it is driven by true *need*, unlike most other services that can trigger or create *needs*

through effective marketing and prompt buyers to act within a defined time period. Unfortunately, healthcare marketers do not have this same type of influence or power. Regardless of tactics, it is the consumer's own body (literally) that controls the timeframe in which they *need* or *demand* healthcare services. For these very reasons, it is not surprising to see a significant discrepancy between change in perception and change in preference. But this does not necessarily mean healthcare marketers should shun marketing. Positive perceptions are key to swaying preference when the consumer's need for healthcare services arises and the option for consumer choice is viable.

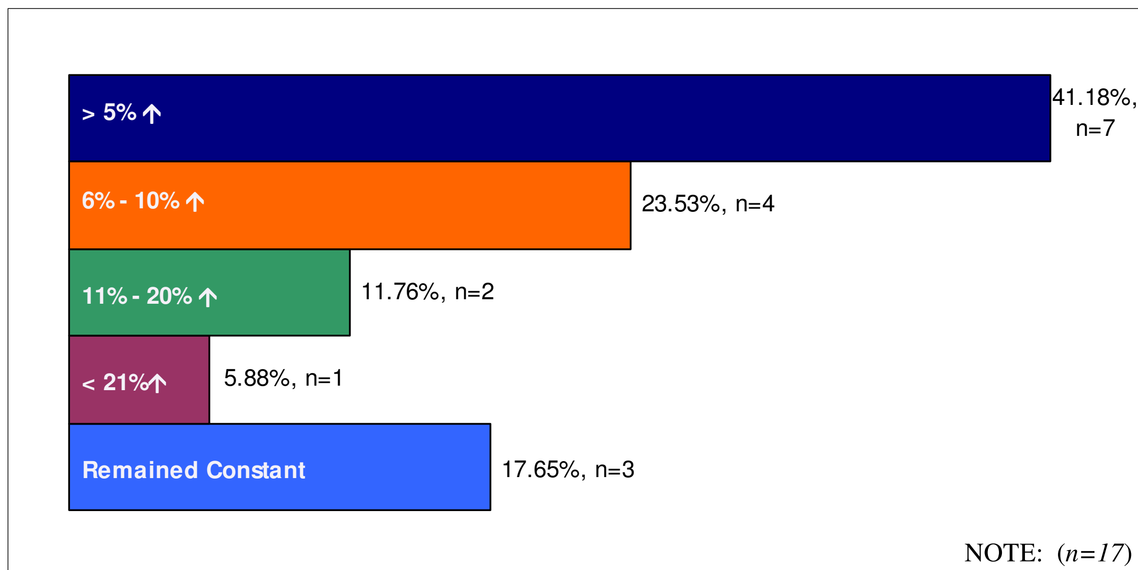

Figure 3: Increase in Consumer Perception of the Hospital Overall as Reported by Hospitals Using Ratings within its Marketing Messages

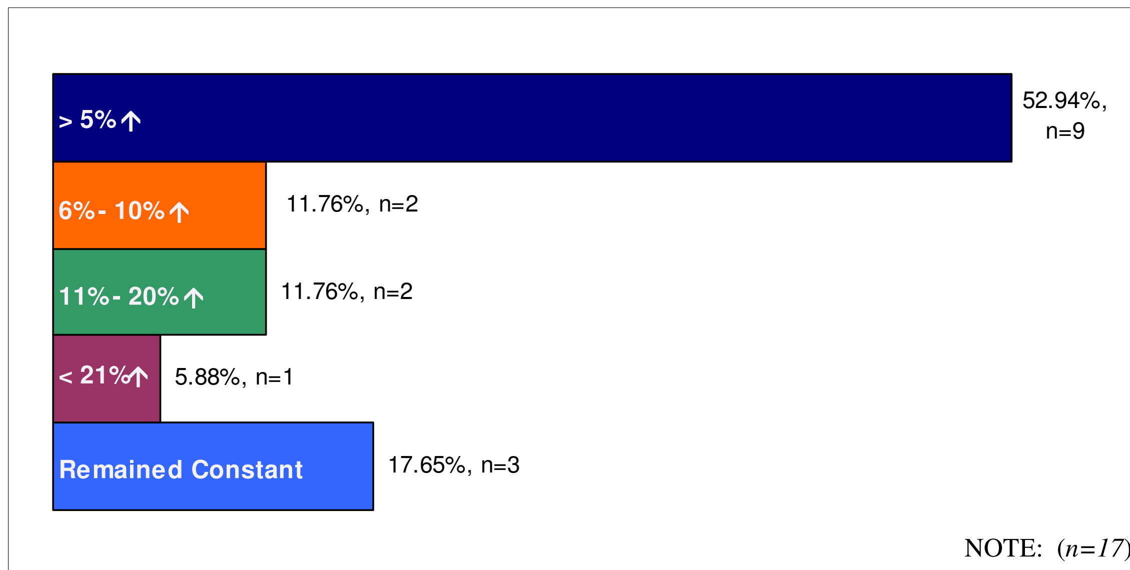

Figure 4: Increase in Consumer Preference for the Hospital Overall as Reported by Hospitals Using Ratings within its Marketing Messages

When evaluating perception versus preference of a specific service line/attribute promoted, there appears to be a much closer correlation among the data presented here. One may accredit this to the fact that when it comes to specific service lines (i e: cardiology, cancer, etc.), the hospital perceived as the best is naturally the hospital the consumer prefers when they're in need of this service. Others may contest that the reverse occurs in that consumers already prefer the better hospital for specific service lines, so their preference naturally follows their perception. Regardless of the rationale, this study demonstrates that marketing of ratings for specific service lines/attributes has played a positive role in altering consumer perceptions and preferences for these particular hospitals (see Figures 5 and 6).

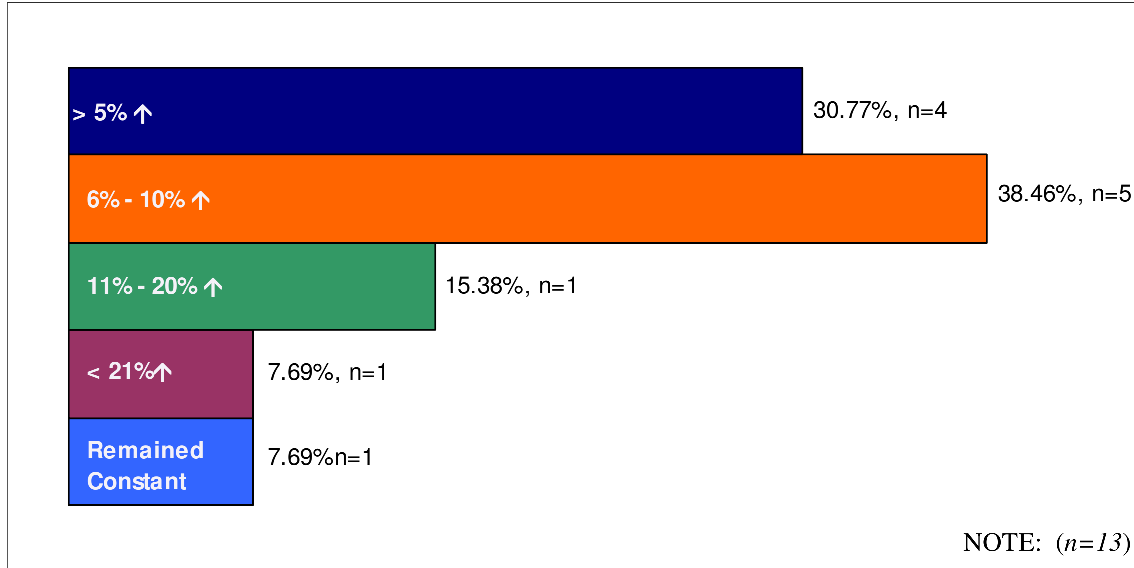

Figure 5: Increase in Consumer Perception for Hospitals' Service Line as Reported by Hospitals Using Ratings with its Marketing Messages

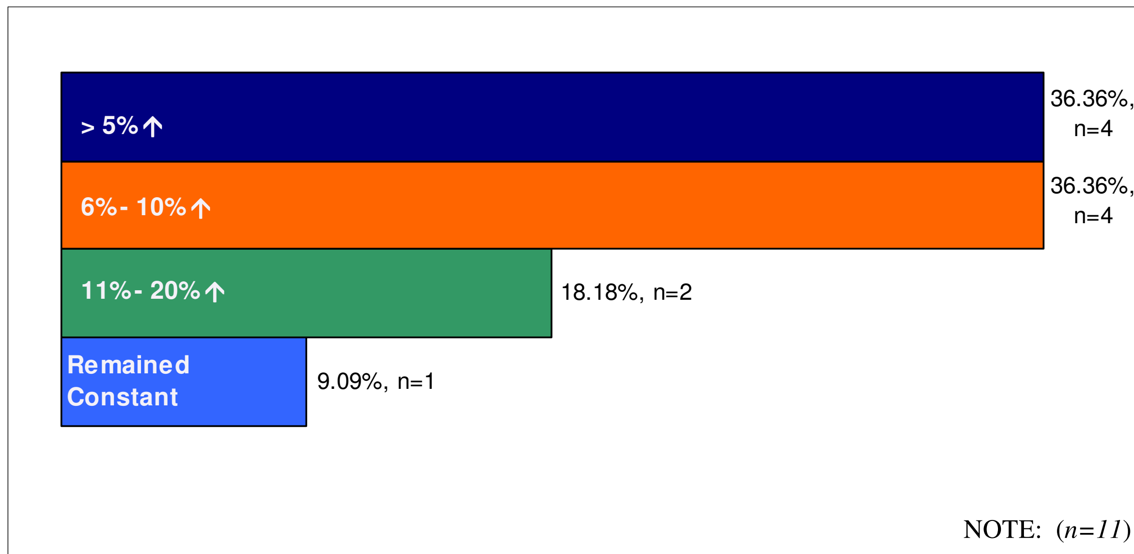

Figure 6: Increase in Consumer Preference for Hospitals' Service Line as Reported by Hospitals Using Ratings with its Marketing Messages

Because there was not a concentrated use of any particular rating organization or award system among the marketers who reported data, the impact of using one particular company over another is assumed to be extraneous information (see Table 8). It is not surprising to see little differentiation in effects based on organizations since healthcare ratings are fairly new to the general public and consumers are not yet fully educated about them. However, as consumers become more educated and begin to understand the differences between the methodologies used by various rating organizations, it is likely that the effectiveness of marketing will have a greater correlation to the specific ratings used.

Table 8: Ratings/Award Organizations Promoted by Hospital Respondents Reporting Data Related to Their Marketing Efforts

Ratings or Award Organization	# of Participants Reporting Data	% of Participants Reporting Data
Solucient	4	21.05%
HealthGrades	3	15.79%
Local Awards	3	15.79%
U.S. News & World Report	3	15.79%
Magnet	2	10.53%
Centers of Excellence	1	5.26%
Employer of Choice (EOC)	1	5.26%
Most Integrated Health Networks (Verispan)	1	5.26%
National Research Corp. (NRC)	1	5.26%

NOTE: (*n=19*)

As demonstrated in earlier sections, there are many shifts occurring in today's arena of healthcare. As consumers continue to take control over their own healthcare decisions and insurance companies begin to take notice of quality and costs, both are craving information and want to be aware of the highest rated hospitals. If marketers focus on convincing consumers that they *want* their specific hospital, as the landscape evolves and it becomes easier for them to get what they want, consumers will *demand* their *desired* hospital. Marketing messages containing quality ratings are helping hospitals to gain their place at the top of consumers' choice set for a new era that is quickly upon us.

Chapter 6: Conclusions and Recommendations

6.1 Conclusions

Secretary of Health and Human Services, Michel Leavitt, released a report in 2006 entitled *Better Care, Lower Cost: Prescription for Value-Driven Health Care*. In this report, Leavitt called for necessary comparison tools that would allow consumers to evaluate a healthcare organization's *value*. Leavitt defined value in healthcare as the "combination of high quality and low cost." The report continued, stating:

> Americans are value-conscious consumers. We clip coupons, check the Web for the best travel prices and value, and carefully research our next car purchase. It's the American way! Given clear information, people will naturally select the best health-care value.
>
> Providing reliable cost and quality information empowers patient choice. Patient choice creates incentives at all levels and motivates the entire system. Improvements come as providers and payers can see how their practice, service, or plan compares to others.
>
> As value in health care becomes transparent, everything improves: costs stabilize; more people are insured; more people get better health care; and economic competitiveness is preserved.
>
> Ultimately, this is a prescription for a value-driven system – a prescription of good medicine that works for everyone. The need for change is self-evident. The will to change exists, and the time to act is now (4).

There's little doubt that hospitals are making efforts to improve quality largely because of mandates and reimbursement incentives created by the federal government; however, the movement of consumer empowerment within healthcare could wield greater power than any legislative body (Destiny Health, 2006). Secretary Leavitt makes a profound point that when given clear and reliable information, consumers become empowered. We are just seeing the beginning of the efforts on the part of public and

private agencies to put this powerful information in the hands of consumers. But at its very least, these agencies have given healthcare marketers a new opportunity.

With 81% (*n=70*) having used ratings or awards in their advertising within the past five years, this study suggests that marketers across the U.S. are indeed taking advantage of this opportunity. For some marketers, public quality reporting has likely forced them to brush up on their public relations efforts to defend less-than-desirable ratings. But for others, as indicated in this study, it's an opportunity to change consumer perception and preference through strategic marketing of positive ratings.

Of the marketers who reported data, an overwhelming 82.35% (*n=14*) saw a positive increase in perception and preference for their hospital overall after using ratings in their marketing messages. This study indicates even greater impact can be made when marketing ratings for specific service lines. Perception of a specific service line increased for 92.31% (*n=12*) marketers who evaluated their efforts following campaigns using rating messages, while preference increased for 90.91% (*n=10*) of the marketers. Interestingly, the remainder of the marketers reported that perception and preference remained constant signifying that there is little negative risk in using ratings within marketing messages. Such positive findings from marketers suggests that utilizing ratings within marketing messages is in fact a valuable tool for increasing perception and preference – the two keys to achieving a marketers ultimate goal: increased market share.

Consumerism refers to the effect consumers' decisions have on a specific industry. Publicly reported quality ratings will have little effect if consumers do not pay attention to them. While the federal government has made minor efforts to promote

quality data to consumers, it has made great strides in promoting transparency requirements to healthcare organizations by tying performance to reimbursement. Healthcare's driving force for encouraging change is mandated governmental regulation and reimbursement rates. But the ability to make high quality ratings work for an individual healthcare organization, in terms of improving perception and preference in the marketplace, is not the responsibility of the federal government. Instead, it's up to the individual healthcare organizations to leverage superior quality within the market to influence consumers. By bringing quality ratings to the forefront of marketing messages, healthcare organizations are playing a vital role in creating more educated, aware, and responsible consumers of healthcare, all the while improving their position within a competitive marketplace.

Strategic marketers who believe in quality healthcare long for the day when true consumerism takes over our industry and buyers consider healthcare purchases much like they consider buying a car or a major household appliance. While it is true this may never be a point within reach because of physician and insurance directives, the proactive approach of informing consumers will no doubt build awareness and, at its least, build a more inquisitive consumer population that may one day force the hand of the directing physicians and payors to select the provider with the highest quality and lowest price point.

As we enter an era of government-mandated transparency, inquisitive consumers, watchful media, and vicious competition, marketing is more important than ever for healthcare organizations. The primary motive of quality rating organizations may be directed at hospitals, but the mere existence of them presents new opportunities for

marketers in an age where "consumers are kings and queens of the marketplace" (Zuckerman & Coile, 2004, p. 21). This study suggests that leveraging ratings in the marketplace and using them within marketing messages can positively impact consumer perception and preference for the hospital.

6.2 Recommendations for Future Studies

This study was conducted under many limitations including time, financial support, and response level. The process of collecting secondary data (data collected by individual respondents), was chosen because of these very limitations. As a web-only survey, non-respondents were not contacted by phone or mail so whether respondents differ greatly from non-respondents is unknown and prevents one to make generalizations about the population as a whole. Future researchers may consider replicating this survey using various survey methods and expanding the sample size to overcome some of these limitations.

Forthcoming studies should also take a more in depth look at individual healthcare organizations and whether or not promoting positive ratings could positively impact perception and preference within the constraints of that marketplace. Exploration of what economic or area-specific factors affect the influence of ratings on the local consumers would be of great importance to future marketers who are considering using ratings within their marketing messages.

It is also recommended that future researchers survey consumers directly regarding their awareness of healthcare ratings, the marketing they've been exposed to regarding ratings of their local healthcare organizations, and the impact marketing has on

their perception and preference for providers. Doing so will insure data is truly comparable rather than relying on secondary reporting by marketers.

Also, as the paradigm shifts, the role physicians and insurance providers play in directing consumers will be of great interest. In other words, as consumers become more empowered (assuming they do), will they go against physician or payor directives? Of similar interest will be the role marketers can play in swaying opinions of physician and insurance providers using quality ratings. Can marketers gain physician and/or payor loyalty by positioning themselves as the quality leader?

While it was not evaluated in this study, there is no denying that creative implementation, medium, and frequency used in promoting rating messages do contribute to the effectiveness of marketing campaigns. For the few who reported perception and preference *remained constant* when marketing ratings, future studies might review these factors to determine if they played a role in the campaign's ineffectiveness. It is important to note that while these marketers reported no change when using ratings in messages, none of the marketers reported negative changes indicating that at their very least, the marketing of ratings does not harm the perception or preference for an organization.

As rating organizations continue to refine their methodologies and quality data becomes more absolute, it is likely to become more understandable, and therefore more influential, to consumers. It is at this point in which consumers may begin to distinguish between the different rating organizations, making the variable of which rating organization is cited potentially more important than was exhibited here in this study. This very factor could open the door for potential studies of which rating organizations

have the most impact when cited by healthcare marketers. Another exploration needed might be the question of what leads consumers to trust these particular rating organizations more than others. Is it the organization's rating criteria that consumers find trustworthy or is it the mere fact that the rating company has gained more market exposure and therefore is inherently perceived as more dependable?

Exactly what effect ratings have on consumers, and what role marketing plays in delivering rating information to consumers, is information that will be vital to healthcare marketers as they move forward in planning strategic marketing initiatives that define their position in the marketplace and is worthy of future studies. Marketers are currently facing the mere dawn of an era where a smorgasbord of organizations – both public and private, governmental and non-governmental – are determined to ensure consumers have access to quality information as it relates to healthcare providers. New rating organizations are emerging daily, methodologies are continuously being revised, and the means in which the data is presented in a consumer-friendly manner is quickly evolving. The ability for marketers to use this phenomenon to their advantage to gain market share is a topic that will only continue to gain interest and prompt much needed research on this subject in the immediate future.

If we are to continue learning about the effectiveness of ratings within marketing messages, research must be done on by individual healthcare organizations, as well as by scholars. Unfortunately, the finding that 71% of healthcare marketers who have used ratings in their advertising don't have data evaluating their advertising efforts leads one to conclude that the industry is not placing great emphasis on research. Yet interestingly enough, marketers are looking for data to substantiate their recommendations and efforts.

One might contend that as a relatively young industry of less than 40 years, healthcare marketing still has a lot to learn. But without a commitment to continued research, the learning curve for healthcare marketers will be much greater than desired.

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Appendix A: Survey Invitation

Dear colleague,

I'm writing to request your assistance in a research project to answer the question I hear many people in our positions ask: **Are healthcare organizations using quality ratings and awards in consumer advertising and if so, how effective is this strategy?**

As a graduate student at Louisiana State University and a healthcare marketing professional myself, I know first-hand how difficult it is to find information on what others are doing and what efforts are most effective in promoting quality. This is why, with the approval of my professors, I have selected this topic for my masters' thesis. Your participation in this electronic survey is vital to the success of this research and its results will be helpful as you plan future marketing strategies.

I am sending this survey to experienced healthcare marketers throughout the U.S. who are knowledgeable about their organization's marketing strategies, initiatives, and results. **If this does not describe your role, please forward this to the appropriate person within your organization**. If you are a consult, please feel free to complete the survey on behalf of one of your clients.

It should only take about 15 minutes to complete this survey and you and your organization can remain anonymous when submitting your responses. **Those who fully complete the survey will be sent a summary of the results if they so choose.** At the end of the survey, you will be asked for your email address. Please know that this is solely for the purpose of sharing the results with you; it will not be tied back to your responses.

Please feel free to e-mail or phone me if you have any questions. I know you are busy and truly appreciate your time and effort in completing this survey. My hope is that by sharing the results with those who participate, we can all gain from this experience.

Please use the link below to begin the survey.

Sincerely,

Rebecca A. Burdette
Graduate Student, Louisiana State University
racosta@lsu.edu, 225.757.8885

http://www.zoomerang.com/survey.zgi?p=WEB226HUC6JV6Z

Appendix B: Electronic Survey Questions

Survey Page 1

Which of the following best describes the healthcare organization for which you are marketing?

- Hospital/health system
- Ambulatory care provider (not hospital affiliated)
- Long-term care provider
- Physician group
- Other, please specify:

Is your healthcare organization

- For-profit
- Not-for-profit
- Other, please specify:

What size is your healthcare organization?

- 0 – 50 beds
- 51 – 100 beds
- 101 – 200 beds
- 201 – 400 beds
- 401 beds or more
- Not applicable

How many locations does your healthcare organization have?

- 1 location
- 2 – 3 locations
- 4 – 5 locations
- 6 or more locations

In which state is your healthcare organization located?

Selection Coding:
Dropdown box listing all U.S. states in alphabetical order

What is your organization's annual external marketing/communications budget excluding salaries? (please consider dollars allocated for all external activities such as advertising, special events, collateral, research, website, etc.)

- Less than $75,000
- $75,001 - $200,000
- $200,001 - $600,000
- $600,001 - $999,999
- $1 million or more

[*]Has your organization used healthcare ratings or awards in its advertising within the past five years?

- Yes
- No

SUBMIT

Skip Coding:
Respondents answering "Yes" to this question are sent to Survey Page 3
Respondents answering "No" to this question are sent to Survey Page 2

[*] Asterisks denote mandatory questions. Most mandates were created to allow for the incorporation of Skip and/or Branching Technology.

Survey Page 2

*Which rating systems or awards have your organization considered using in your marketing messages within the past five years? Please check all that apply.

- ○ HealthGrades
- ○ Magnet
- ○ National Research Corporation
- ○ Solucient
- ○ U.S. News & World Report
- ○ Other, please specify:

Which factors describe what has kept your organization from using ratings/awards in its marketing messages? Please check all that apply.

- ☐ Adding ratings or awards to our marketing messages are not likely to achieve our marketing goals.
- ☐ We lack the financial resources to properly promote ratings or awards.
- ☐ My organization does not use ratings or awards in advertising.
- ☐ My organization does not believe in the validity of healthcare ratings or awards.
- ☐ My organization has not received high ratings or awards.
- ☐ My competitors have higher ratings or greater awards than my organization does.
- ☐ Other, please specify:

SUBMIT

Skip Coding:
Respondents are forwarded to Page 5

Survey Page 3

Which healthcare rating system or awards has your organization used in its advertising within the past five years? Please check all that apply.

- ☐ HealthGrades
- ☐ Magnet
- ☐ National Research Corporation
- ☐ Solucient
- ☐ U.S. News & World Report
- ☐ Other, please specify:

*Of the healthcare ratings/awards your organization has used in its advertising within the past five years, on which do you have data evaluating its marketing efforts?

If you have data supporting more than one of your campaigns, please select the most recent.

- ○ We do not have data evaluating our marketing efforts related to ratings/awards campaigns
- ○ HealthGrades
- ○ Magnet
- ○ National Research Corporation
- ○ Solucient
- ○ U.S. News & World Report
- ○ Other, please specify:

SUBMIT

Skip Coding:
Respondents are forwarded to Survey Page 4

Survey Page 4

The following questions reference the most recent ratings/awards advertising campaign for which you indicated you have data.

In what year was your initial **benchmark data** collected for your campaign?

Selection Coding:
Dropdown box listing the following options:
2000 or Prior
2001
2002
2003
2004
2005
2006

In what year was your **most recent comparison data** collected for your campaign?

Selection Coding:
Dropdown box listing the following options:
2000 or Prior
2001
2002
2003
2004
2005
2006
2007

The following questions reference your most recent comparison data collected.

What was the percent-change in **consumers' overall perception of your organization's reputation** following your campaign?

- Less than 5% increase
- 6% – 10% increase
- 11% – 20% increase
- Greater than 21% increase
- Overall perception remained constant
- Overall perception decreased
- Overall perception was not measured

What was the percent-change in **consumers' preference for your organization** following your campaign?

- Less than 5% increase
- 6% – 10% increase
- 11% – 20% increase
- Greater than 21% increase
- Preference remained constant
- Preference decreased
- Preference was not measured

What was the percent-change in **consumers' overall perception for the specific service line/attribute promoted** through your campaign?

- Less than 5% increase
- 6% – 10% increase
- 11% – 20% increase
- Greater than 21% increase
- Perception of service line/attribute remained constant
- Perception of service line/attribute decreased
- Perception of service line/attribute was not measured

What was the percent-change in **consumers' preference for the specific service line/attribute promoted** through your campaign?

- Less than 5% increase
- 6% – 10% increase
- 11% – 20% increase
- Greater than 21% increase
- Perception of service line/attribute remained constant
- Perception of service line/attribute decreased
- Perception of service line/attribute was not measured

What was **consumers' recall** of your campaign?

- ○ Less than 10% recall
- ○ 11% – 20% recall
- ○ 21% – 35% increase
- ○ 36% – 50% recall
- ○ 51% – 70% recall
- ○ Greater than 71% recall
- ○ Recall was not measured

Please describe any notable internal or external factors that may have affected the data you just reported (ie: high margin of error in data, drastic change in marketplace due to such things as competition or natural disasters, etc.).

SUBMIT

Skip Coding:
Respondents are forwarded to Survey Page 5

Survey Page 5

Please take a moment to answer these few final demographic questions.

How long have you been with the healthcare organization for which you are currently marketing?

- ○ Less than 5 years
- ○ 6 – 15 years
- ○ 16 or more years

How long have you been in the healthcare marketing field?

- Less than 5 years
- 6 – 15 years
- 16 or more years
- I am not in the healthcare marketing field

Which of the following most accurately describes your current role in the healthcare organization you represent?

- Marketing/Public Relations
- Administrative
- Other, please specify

When it comes to using healthcare ratings or awards in your advertising, how are decisions made in your organization?

- I am the final decision-maker
- I recommend decisions (supervisor/board has final approval)
- Other, please explain

What is your age?

- 34 or younger
- 35 - 44
- 45 - 54
- 55 or older

What is your gender?

- Male
- Female

What is your race?

- ○ Caucasian/White
- ○ African American
- ○ Asian/Pacific Islander
- ○ Hispanic
- ○ Other, please specify

SUBMIT

Skip Coding:
Respondents are forwarded to Survey End Response Page 1

Survey End Response Page 1

Thank you for participating in this survey. Please know that your responses to this survey will remain completely anonymous and not be used to reveal information about you or your particular organization. **Any information you provide at this point will not be tied back to your survey responses.**

For those who have fully completed this survey, we would be happy to send you a summary of the survey results. **To receive the summary, please enter your email address here:**

The final report will include an in-depth analysis of the survey results, as well as examples of various campaigns and their strengths and weaknesses. If you are willing to share additional information about your marketing campaign such as creative samples and strategy information, please enter your contact information below. **Those doing so will receive a full copy of the final report.**

Name:
Organization Name:
Phone:
Email:

SUBMIT

Skip Coding:
Respondents are forwarded to Survey End Response Page 2

Survey End Response Page 2

Thank you for your participation in this survey. The data gathered here will be helpful to you and your colleagues in planning future marketing strategies.

Appendix C: Survey Results

Which of the following best describes the healthcare organization for which you are marketing?		
Hospital/health system	71	84%
Ambulatory care provider (not hospital affiliated)	0	0%
Long-term care provider	1	1%
Physician group	6	7%
Other, please specify	7	8%
Total	85	100%

Is your healthcare organization		
For-profit	10	12%
Not-for-profit	74	86%
Other, please specify	2	2%
Total	86	100%

What size is your healthcare organization?		
0 - 50 beds	1	1%
51 - 100 beds	4	5%
101 - 200 beds	11	13%
201 - 400 beds	17	20%
401 beds or more	40	48%
Not applicable	11	13%
Total	84	100%

How many locations does your healthcare organization have?		
1 location	20	24%
2 - 3 locations	11	13%
4 - 5 locations	14	16%
6 or more locations	40	47%
Total	85	100%

In which state is your healthcare organization located?		
Alabama	0	0%
Alaska	0	0%
Arizona	1	1%
Arkansas	1	1%
California	3	3%
Colorado	3	3%
Connecticut	1	1%
Delaware	2	2%
District of Columbia	0	0%
Florida	5	6%
Georgia	1	1%
Hawaii	0	0%

Idaho	1	1%
Illinois	4	5%
Indiana	6	7%
Iowa	0	0%
Kansas	1	1%
Kentucky	1	1%
Louisiana	2	2%
Maine	0	0%
Maryland	3	3%
Massachusetts	1	1%
Michigan	3	3%
Minnesota	1	1%
Mississippi	0	0%
Missouri	4	5%
Montana	1	1%
Nebraska	1	1%
Nevada	0	0%
New Hampshire	0	0%
New Jersey	2	2%
New Mexico	1	1%
New York	2	2%
North Carolina	3	3%
North Dakota	1	1%
Ohio	7	8%
Oklahoma	0	0%
Oregon	3	3%
Pennsylvania	1	1%
Rhode Island	0	0%
South Carolina	2	2%
South Dakota	0	0%
Tennessee	2	2%
Texas	8	9%
Utah	0	0%
Vermont	0	0%
Virginia	3	3%
Washington	2	2%
West Virginia	1	1%
Wisconsin	2	2%
Wyoming	0	0%
Total	86	100%

What is your organization's annual external marketing/communications budget excluding salaries? (please consider dollars allocated for all external activities such as advertising, special events, collateral, research, website, etc.)		
Less than $75,000	2	2%
$75,001 - $200,000	3	4%
$200,001 - $600,000	20	24%
$600,001 - $999,999	19	23%
$1 million or more	40	48%
Total	84	100%

Has your organization used healthcare ratings or awards in its advertising within the past five years?		
Yes	70	81%
No	16	19%
Total	86	100%

Which rating systems or awards have your organization considered using in your marketing messages within the past five years? Please check all that apply.		
HealthGrades	6	38%
Magnet	2	12%
National Research Corporation	1	6%
Solucient	3	19%
U.S. News & World Report	3	19%
Other, please specify	10	62%

Which factors describe what has kept your organization from using ratings/awards in its marketing messages? Please check all that apply.		
Adding ratings or awards to our marketing messages are not likely to achieve our marketing goals.	4	25%
We lack the financial resources to properly promote ratings or awards.	3	19%
My organization does not use ratings or awards in advertising.	4	25%
My organization does not believe in the validity of healthcare ratings or awards.	0	0%
My organization has not received high ratings or awards.	3	19%
My competitors have higher ratings or greater awards than my organization does.	2	12%
Other, please specify	6	38%

Which healthcare rating system or awards has your organization used in its advertising within the past five years? Please check all that apply.		
HealthGrades	23	33%
Magnet	20	29%
National Research Corporation	11	16%
Solucient	33	47%
U.S. News & World Report	22	31%
Other, please specify	36	51%

Of the healthcare ratings/awards your organization has used in its advertising within the past five years, on which do you have data evaluating its marketing efforts? If you have data supporting more than one of your campaigns, please select the most recent.		
We do not have data evaluating our marketing efforts related to ratings/awards campaigns	50	71%
HealthGrades	3	4%
Magnet	2	3%
National Research Corporation	1	1%
Solucient	4	6%
U.S. News & World Report	3	4%
Other, please specify	7	10%
Total	70	100%

The following questions reference the most recent ratings/awards advertising campaign for which you indicated you have data.

In what year was your initial benchmark data collected for your campaign?		
2000 or Prior	7	35%
2001	1	5%
2002	0	0%
2003	3	15%
2004	3	15%
2005	6	30%
2006	0	0%
Total	20	100%

In what year was your most recent comparison data collected for your campaign?		
2000 or Prior	1	5%
2001	0	0%
2002	0	0%
2003	1	5%
2004	1	5%
2005	1	5%
2006	10	53%
2007	5	26%
Total	19	100%

The following questions reference your most recent comparison data collected.

What was the percent-change in consumers' overall perception of your organization's reputation following your campaign?		
Less than 5% increase	7	37%
6% - 10% increase	4	21%
11% - 20% increase	2	11%
Greater than 21% increase	1	5%
Overall perception remained constant	3	16%
Overall perception decreased	0	0%
Overall perception was not measured	2	11%
Total	19	100%

What was the percent-change in consumers' preference for your organization following your campaign?		
Less than 5% increase	9	47%
6% - 10% increase	2	11%
11% - 20% increase	2	11%
Greater than 21% increase	1	5%
Preference remained constant	3	16%
Preference decreased	0	0%
Preference was not measured	2	11%
Total	19	100%

What was the percent-change in consumers' overall perception for the specific service line/attribute promoted through your campaign?		
Less than 5% increase	4	22%
6% - 10% increase	5	28%
11% - 20% increase	2	11%
Greater than 21% increase	1	6%
Perception of service line/attribute remained constant	1	6%
Perception of service line/attribute decreased	0	0%
Perception of service line/attribute was not measured	5	28%
Total	18	100%

What was the percent-change in consumers' preference for the specific service line/attribute promoted through your campaign?		
Less than 5% increase	4	22%
6% - 10% increase	4	22%
11% - 20% increase	2	11%
Greater than 21% increase	0	0%
Perception of service line/attribute remained constant	1	6%
Perception of service line/attribute decreased	0	0%
Perception of service line/attribute was not measured	7	39%
Total	18	100%

What was consumers' recall of your campaign?		
Less than 10% recall	2	11%
11% - 20% recall	6	32%
21% - 35% increase	0	0%
36% - 50% recall	1	5%
51% - 70% recall	2	11%
Greater than 71% recall	0	0%
Recall was not measured	8	42%
Total	19	100%

Please take a moment to answer these few final demographic questions.

How long have you been with the healthcare organization for which you are currently marketing?		
Less than 5 years	43	51%
6 – 15 years	25	29%
16 or more years	17	20%
Total	85	100%

How long have you been in the healthcare marketing field?		
Less than 5 years	13	15%
6 – 15 years	31	36%
16 or more years	41	48%
I am not in the healthcare marketing field	1	1%
Total	86	100%

Which of the following most accurately describes your current role in the healthcare organization you represent?		
Marketing/Public Relations	69	81%
Administrative	7	8%
Other, please specify	9	11%
Total	85	100%

When it comes to using healthcare ratings or awards in your advertising, how are decisions made in your organization?		
I am the final decision-maker	25	29%
I recommend decisions (supervisor/board has final approval)	55	65%
Other, please explain	5	6%
Total	85	100%

What is your age?		
34 or younger	9	11%
35 - 44	24	29%
45 - 54	36	43%
55 or older	15	18%
Total	84	100%

What is your gender?		
Male	25	29%
Female	60	71%
Total	85	100%

What is your race?		
Caucasian/White	82	98%
African American	1	1%
Asian/Pacific Islander	0	0%
Hispanic	1	1%
Other, please specify	0	0%
Total	84	100%

Vita

Rebecca Acosta Burdette was born in Baton Rouge, Louisiana, on April 3, 1978, to Debra Acosta Davis and Richard Acosta, Jr. She graduated from Brusly High School in 1996 and received a Bachelor of Arts degree with a major in mass communications and minor in speech communications, from Louisiana State University (LSU) in 2000. Not waiting until graduation, Rebecca worked from 1996-2000 to build a professional resume. Assuming roles such as marketing assistant, account executive assistant, and production assistant, Rebecca gained much experience in the marketing and advertising arena, spanning an array of industries including automotive, retail, sports, public service, and fundraising.

Upon graduation, Rebecca began her full-time career at Louisiana Travel Promotion Association (LTPA). Her initial responsibilities at this nonprofit organization focused on promoting Louisiana's tourism businesses included production of the state's 300-plus page travel guide distributed to more than one million consumers each year. As the internet became a powerful marketing tool within the travel industry, Rebecca worked to improve the website that complemented the printed travel guide. She was instrumental in the redevelopment and success of the state's travel website. Rebecca also spearheaded LTPA's initiative to help its 1,000 members of destination business owners to promote their businesses using interactive websites and marketing.

In 2004, Rebecca assumed the role of Marketing Strategist for Louisiana State University. This position not only gave her the opportunity to market her beloved alma mater, but also return to the classroom to pursue her master's degree – a personal goal

she had set for herself as a teenager. As a strategist, Rebecca helped to plan and implement many of LSU's notable initiatives including the university's largest ever fundraising campaign – *Forever LSU*.

Breathing new life into both her personal and professional life, Rebecca had an exciting year in 2006. In April, she married her best friend, Damian Burdette, and two months later, joined Baton Rouge General Medical Center as their new Marketing and Public Relations Manager. In her current role at the General, Rebecca is responsible for managing consumer and physician communications, including collateral materials, advertising, special events, and media relations. As a community-owned, not-for-profit hospital, some consumers view the General as the less preferred provider compared to its larger, private competitor. However, the General's strong commitment to the community, compassionate service, and quality healthcare, has recently earned the General local, regional, and national recognition as a leader in healthcare quality. Rebecca and her team are strategically working to share this good news with the community and are slowly, but surely, seeing positive impacts on perception and preference because of their creative, consistent use of ratings within marketing messages.

While her role as a marketer has changed little throughout her career, Rebecca has gained experience in a variety of industries from tourism to higher education to healthcare. All similar in many ways, Rebecca continues to build on her core marketing skills using innovation and strategic thinking to positively impact the organizations for which she works.