

# Marketing plan to extend the nursing home's occupational, physical, and speech th...

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## **Marketing plan to extend the nursing home's Occupational, physical, and speech therapy**

### **INTRODUCTION**

Changes occurring in Healthcare delivery and Medicine are the result of social, economical, technological, scientific forces that have evolved in the 21st century. Among the most significant changes are shift in disease patterns, advanced technology, increased consumer expectations and high costs of health care. These factors have redefined medical practices to fit into the changing health delivery system. Thus, Medical Profession is 'Accountable' to the society. i. e. obliged to the laws regulating the professional activity. This 'accountability' is usually spelt out in "Patient Care Documents" established by hospital associations and medical associations or councils of every country (Suzanne, 2004). In addition, medical profession has defined its standards of accountability through a formal code of Ethics. The Riverside Convalescent Hospital, 375 Cohasset Road , Chico, CA 95926, with a patient capacity of 99 has now planned to extend the Occupational, Physical, and Speech Therapy services to the elderly community.

### **THE EXECUTIVE SUMMARY and BACKGROUND**

### **THE STRATEGIC MARKETING PLAN (SMP)**

The Strategic Marketing Plan (SMP) of this health care organization aims to target the elderly community in need of occupational, physical therapy and

speech therapy in the city of Chico initially and then in the entire state of California. The prime reason for targeting the elderly community is that

1. There has been a recent significant increase in the number of elderly patients in hospice compared to those in palliative care units of hospitals and
2. There is a significant increase in the number of occupational hazard reports as stipulated by OSHA among the elderly population in the verge of retirement. in various industries.

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#### THE HOSPICE CASES

These days elderly patients prefer to receive their end life care in a hospice rather than in palliative care units of hospitals. Hospice is a coordinated programme of inter disciplinary care provided primarily in the home of the terminally ill patients. The Palliative care is the comprehensive care for patients whose disease is not responsive to cure and hence are terminally ill. In the past two decades there has been a study of enormous magnitude in the palliative care segment and various factors have been identified like, respecting patient's goals, preferences and choices, attending to the medical, emotional, social and spiritual needs of the person, using strengths of interdisciplinary resources, acknowledging and addressing concerns and building mechanisms and systems of support.

Many terminally ill patients suffer only when they do not receive adequate care for the symptoms accompanying their serious illness. But, Unfortunately, there is a perennial shortage of occupational, physical and speech therapists in the health care system in the USA. Thus, there is a growing demand and proportional short supply of professionals. Physical therapy and speech therapy are vital in such settings because of the following reasons;

1. Pain experienced by patients and
2. Problems in patient communications resulting in inadequate patient care.

Chronic pain is a pain, which lasts for more than six months. Chronic pain is further classified based on its etiology as ' non-malignant' and ' malignant pain'. Non – malignant is non-cancer related pain and malignant pain is cancer related. Chronic pain persists in spite of normalization after injury or a disease and often interferes with productivity aspect of the individual. Chronic pain depresses, debilitates and affects the quality of life (Cole, 2002). Hence, chronic pain should be managed by the use of rehabilitative techniques when the pain is primarily of a non-malignant origin. The Chronic pain cases need more attention and resources than a single clinician usually can usually provide (Cole, 2002). Chronic non-malignant pain can be further described as ' mild', ' moderate' and ' severe', based on the intensity of the pain. Studies on interventions for patients with chronic pain syndromes has revealed that such patients always benefited from follow-up visits. Multiple visits, extended over a long-term with individualized interventions were most

effective. Education of health care providers and the amount of time spent with the patients were important for positive outcome (Frich, 2003). Chronic pain has been found to demand a rehabilitative model rather than a treatment model for management. Studies on such models suggest that Management should be holistic and rigorous with a possible role for alternative therapies (Wilson et. al, 1992). According to Bedard , chronic nonmalignant pain remains grossly under treated in most patients. The reasons he cites for this care; low priority of pain relief in the health care; lack of knowledge and fears of opioid side effects. A recent publication on chronic non-malignant pain, establishes the effect of physical exercise in such patients ( Fran Hall, 2003). The study stresses the importance of exercise in terms of increased physical activity in pain management. Previous Studies have also shown that exercise, when incorporated into a chronic pain programme, is beneficial (Fordyce, 1973; Jensen et al, 1991; Burns et al, 1998). One of the reasons for this, especially in the case of low back pain, is that the spinal muscles inevitably become weaker in inactive patients.

Studies pertaining to specific verbal communication interactions in such elderly patients have been carried out (Jones et. al 1986). The studies were carried out under the categories ' words spoken', ' commands given', ' statements made', ' Questions asked and answered'. The studies highlighted the need for the health care professionals to be aware of the implications of communication problems. Data was collected by observation and take recording of the conversations. Another studies on communication with

severely demented patients have shown strong task orientations and low verbal interactions (Edberg et, al. 1995) . The studies conclude that health care providers may become stressed by patients communication problems and hence need to be helped out in such a way that they will have time energy and commitment to communicate with the patients. Pain evaluation in individuals who are cognitively impaired is difficult and these individuals do not respond to traditional approach to pain assessment (Weiner et. al, 1999). Cognitive impairments pose a serious barrier on the reliability of geriatric assessments. Effects of cognitive impairment on the reliability of geriatric assessments has been studied recently to explore the relationship between cognitive status and reliability of multidimensional assessment data. The studies have proved that the reliability of the patients communication and sensory ability are affected by cognitive status. Hence caution should be exercised in treating cognitively impaired terminally ill patients. The cognitive impairment that contributes to unreliable assessment of patients include those related to communicating, vision and hearing . Thus, communications is complex with different aspects of perception and practice (Sirkka, 1996). Non-speaking patients are the worst affected and it is important to improve their communication to allow them receive care and comfort.

#### THE OCCUPATIONAL HAZARD CASES

The staggering number of work-related accidents in U. S. A is alarming. 6, 026 U. S workers died recently in workplace incidents at work and 6. 2 million suffered from workplace injuries. In 2004, 5, 703 fatalities have been

reported of which 1004 were due to contact with equipments, 815 because of falls, 459 due to exposure to harmful substances and 159 due to fire and explosions. The Occupational Safety and Health Act (OSHA) was passed in 1970 to assure so far as possible every working woman and man in the Nation safe and healthy working conditions and to preserve human resources. The Occupational Safety and Health Act in 1970 created the Occupational Safety and Health Administration within the Department of labour in U. S. A. In 2000, 5. 7 million injuries were reported in private sector alone. The problems encountered in such elderly population who may be nearing their retirement in industries are mostly due to the chronic exposure over a period of time to such occupational hazards.

These include Cumulative trauma disorders or Repetitive motion injuries are injuries of the muscles, nerves, tendons, ligaments, joints and spinal discs caused by stress and strains. One of the common conditions is Carpel tunnel syndrome, which causes tingling or numbness in the fingers. Without proper treatment employees with this syndrome can permanently lose feeling in their hands. This trauma disorder is common in meat cutters, fish filleters, cooks, textile workers, violinists, flight attendants and those workers whose jobs require repetitive motion of the fingers, hands or arms. Ergonomic techniques have been recommended and successfully used to improve or correct cumulative trauma disorders. The extensive use of computers and video display terminals in organizations have been the causative agent for complaints like blurred vision, sore eyes and glare in employees. Muscular aches, pain in the neck are common complaints of VDT operators.

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More than 65, 000 chemicals are currently in use in U. S. A with which human beings come into constant contact. Many of these chemicals are harmful and pose a serious health hazard on chronic exposure especially the population in their late fifties. Numerous chemicals have been designated as hazardous to biological system and these chemicals pose an occupational health hazard to workers who are constantly in contact with them. These chemicals are often toxic, mutagenic/carcinogenic, causing serious diseases like Cancer and disabilities of various kinds. Even children born to women working in nickel refinery have been found to have Genital malformations. This offers understanding of the seriousness of occupational hazards due to chemicals. More than 1 million U. S workers are at risk of silicosis; most of them are sand blasters who are exposed to crystalline silica. Silicosis leads to death and silicosis victims are high risk tuberculosis patients. Asbestos workers have the risk of two types of cancer, i. e. cancer of the lung tissue and mesothelioma, cancer of the thin membrane surrounding the lung. The biggest problem here is that the diseases do not develop immediately but appear after a few years of exposure. Workers, exposed to Asphalt used in road paving, riding, and concrete work have the risk of skin cancer. Lead has a toxic effect on the nervous system. High exposure of lead damages kidneys. Manual metal arc is a common process where the workers are exposed to the fumes. The welding workers have a high exposure of metal fumes and the exposure depends on place, confined space, workshop or open air. The metal fumes depend on not only the Aluminium but also the process involved which may produce gases like acetylene, carbon monoxide,



oxides of nitrogen , ozone, phosgene and tungsten. The metal fumes primarily enter the human system by inhalation route namely Respiration. The deposition of these inhaled metallic particles is influenced by its physical and chemical properties and a variety of host factors. In the lungs, these particles produce a variety of reactions depending on the concentration, duration of the exposure of the particles, and degree of exposure. All Metallic particles greater than 10m are deposited on the Mucous membrane in the nose and pharynx. Particles between 3mm and 10 mm are deposited throughout the trachea of the lungs. Particles less than 3mm are deposited in the alveoli and cause serious hazards. These particles have a fair chance of being carried into the blood stream and cause Hepatotoxicity and Nephrotoxicity.

Studies have also proved that exposure of workers to these metal fumes aged between 20-64, admitted to 11 hospitals in England during the period between 1996-1999, caused health hazards and is a classic case of occupational hazard of metal fume exposure (Palmer, 2003). Further studies on 27 welders with long-term exposure to these metal fumes revealed a reversible increase in the risk of Pneumonia. In the sputum, cell counts, soluble levels of the metal, levels of Interleukin-8, tumour necrosis factor- $\mu$ , myeloperoxidase, metalloproteinase -9, Immunoglobulin (Ig)A,  $\mu$  2-macroglobulin and unsaturated metal binding capacity were analyzed and in the blood samples, evidence of neutrophil activation and IgG pneumococcal antibodies were analyzed. The studies concluded that the local inflammatory response was affected by chronic exposure.

All welding workers thus, are exposed to acute or chronic respiratory disease. Welding fumes cause lung function impairment, obstructive and restrictive lung disease, cough, dyspnea, rhinitis, asthma and even carcinoma of the lungs. These welding workers also suffer from eye irritation, photokeratitis, cataract, skin irritation, erythema, pterygium, non-melanocytic skin cancer and infertility.

The recent studies on thyroid functions of the welders exposed to metal fumes have thrown light on the seriousness of the exposure hazard. (Zaidi, 2001). Studies were conducted on 20 healthy male workers with an average occupational exposure of 13-18 years . Serum analysis for serum thyrotropin (TSH) was done by solid phase immunoradiometric assay( TSH/IRMA ). Serum total T3 and T4 were measured by radio immunoassay ( RIA ). Statistical analysis was done using student's ' t' test. The levels of TSH 7. 34 (against the normal 0. 81-3. 2m IU/ml) and 6. 56 respectively indicated thyroid disorders.

Thus, there is a fair chance of these occupational hazard exposure cases to turn to hospice due cancer, kidneyfailure, COPD and other terminal complications. Thus, targeting such a elderly population creates a perennial supply of cases (customers) over a period.

#### THE ORGANIZATIONAL and MARKETING MISSIONS

The Riverside Convalescent Hospital primarily is committed to the principles of patient self care on the principles of Dorothea Orem (1971) with emphasis on client's self-care needs. Self-care, according to Orem, is a learned, goal-

oriented activity directed towards the self in the interest of maintaining life, health, development and well being. The ultimate emphasis of Orem's theory is on client's self care. Accordingly, care is needed when the client is unable to fulfill biological, psychological, developmental or social needs and the health care giver determines by duty why a client is unable to meet the needs or what must be done to enable the client to meet them. Hence, the organization wants to project this programme as A Service to Safeguard the Dignity of the Terminally Ill. This is relevant in the present day health scenario where euthanasia and physician assisted deaths have found a legal niche as in the State of Oregon. The program aims to care those not cared human beings. Euthanasia has drawn the attention of every social conscious individual across the globe. Karen Yanoch who was terminally ill with liver cancer decided to end her life by drinking a bitter solution of a lethal barbiturate. She took several small sips and a final gulp of the solution, slipped into a coma three minutes later before dying shortly afterwards. This happened in Oregon, U. S. A., which has a law, which provides for assisted suicide or Euthanasia. The Oregon law allows adults with terminal diseases who are likely to die within six months to obtain lethal doses of drugs from their doctors. Madison County authorities charged Dr. James Bischoff with murder because he gave 85-year-old Kathryn Dvarishkis a lethal drug to let her die. She was administered two doses of fentanyl in a 10-minute interval and she died moments later. Nancy Curzon met with a car accident and from then on remained in a persistent vegetative state. The U. S. Supreme court refused to allow her feeding tubes to be removed to let her

die because there was no concrete evidence to that regard from Nancy herself.

The first case is of a patient who has been allowed to die as per the “ Death with Dignity Act” passed in 1994 in the State of Oregon, U. S. A. The second case is a Direct Euthanasia, where the doctor has been an agent in inducing a patient’s death by giving a lethal drug in a state euthanasia is not legal. The third case is of a situation where there is no request of the patient to die based on his/her own will.

Thus, decisions at the end of life are always difficult ones to make creating a conflict of morality, Ethics, and the law. Another example of a patient with a terminal illness in U. K. fighting for her right to die is Diana Pretty with a motor neuron disease. Her request was turned down by the Government and she then went to the British Courts and the European Court of Human Rights to fight for this right. All the Courts refused her request. A survey in the Pulse magazine (Nov 1997) proved this point and showed an alarming 46. 5% of GPs helping assisted suicide. This is against the law in U. K and medical staff face prosecution on such acts.

In Countries and States where Euthanasia has a legal validity, it is an act on purpose, performed by a third person, in order to end life of a person who has requested for this act. Only a physician can perform this act. The doctor can perform euthanasia only when the patient is of major age or an emancipated minor. The patient is of full legal capacity and conscious; the request is voluntary, well considered and repeated; the patient is dealing

with unbearable and consistent physical or psychological pain or suffering as a result of an illness or an accident and cannot be cured. The doctors are allowed to perform Euthanasia when the following rules are followed:

The patient needs to be informed about his health situation and life expectancy. The doctor is obliged to discuss the possible therapies, palliative care and the consequences. Based on the discussion, the doctor has to clear that there is no other alternative than euthanasia and the request of the patient is based on his own will. A second opinion has to be obtained from another doctor. The doctor has to wait for a period of at least one month between the written request of the patient and euthanasia.

However, in all cases a written request is an essential component. A written request is composed, dated and signed by the patient requesting for euthanasia. In cases, where the concerned patient is not physically in a state to communicate, a living will regarding euthanasia valid for a maximum of five years can be taken after adding it to the Medical file record. After performing euthanasia, the doctor has to report to the Legal governing bodies. Euthanasia has been found to be acceptable to two thirds of Oncology patients in U. S. A (Emanuel 1996). But Euthanasia is illegal in U. K. Recently investigations have been ordered into deaths of 11 patients at a psychiatric hospital in the mid 1990s after allegations of euthanasia. The 250 bed hospital is part of the South Derbyshire Mental Health Trust. A U.

Nursing home in Birmingham has been closed after reported deaths of twenty-eight patients in 2002-2003. A law currently proposed by Lord Joff, debated in the House of Lords, gives a framework for euthanasia in U. K. His

proposal states that only patients who are terminally ill and judged to have less than six months to live would be eligible for an assisted death. In most of the countries removing or denying treatment without consent from the patient is seen as clear murder. Euthanasia may be direct or indirect.

Indirect methods of euthanasia are defined by an individual himself/herself taking the final step of inducing death. Direct methods are defined by the involvement of clinicians and is legal in Netherlands, Columbia, Japan and Belgium. Voluntary Euthanasia is carried out with the fully informed request of an adult patient or his proxy. In Britain, a High Court Judge recently cleared the legal hurdles for an euthanasia case. The judge permitted the husband of Mrs. Z to accompany her to Switzerland to help her die. Mrs. Z (her anonymity protected by a court ruling) suffered from an incurable brain disease and wanted to go to 'Dignitas' an organization in Switzerland, which helps people to die. After the court ruling the women flew to Zurich where she took a lethal dose of barbiturates in a home accompanied by a doctor nurses and a lawyer. The British Court had said that the law should not interfere with her rights to die weakening the barriers that prevent assisted suicide in English Law, under which it is an offence that could take the doctor up to 14 years in prison.

This program has a huge business potential because of the basic demand for such services even in normal patient care sector. But any innovation in such normal population may not create a sensible sensation or draw economically viable attention from the public. This is because of the already existing infrastructure and facilities. For example, there are enough Heart care

organizations in USA to feed the demand of the entire population of USA and there is a low chance of drawing the attention of a economically significant population that will fetch us business. Further, targeting elderly population has its own merits.

1. Health care of elderly population demands enormous resources of time, energy and money. Hence, every family looks up to any such programs with some faith element.
2. Care of terminally ill population is thus still more stressful for the family in a hospice setting.
3. Any hospice setting requires a inter disciplinary care provided primarily in the home of the terminally ill patients.
4. Such patients are usually immobilized and it is not medically advisable to take them to a hospital for such therapies.

Thus, the hospital administration plans to first identify such hospice cases. Identification can be done by a simple survey of the number of patients referred to hospice from their palliative care units by preference. The next step involves calling up the family and offering our services. The fees will be called Service charges gracefully. The service will mean so much for the patient in terms of pain relief without opioids and other drug addiction or their improved ability to communicate with their family and health care team. For the patient's family, the service saves them from the stress of taking them to a health care center. It is estimated to identify at least 1000 such cases

initially. OSHA requirements demand that organizations with eleven or more employees should maintain records of work related occupational hazards. A recordable case is an injury or illness that results in death, days away from duty, restricted work or transfer to another job due to disability, or medical treatment beyond first aid (Bohlander, 2004). Thus, identification of such patients can be done by scanning these records.

From the organization view point, a cost benefit analysis on the employment of a speech therapist or a physiotherapist in a nursing home shows that such professionals are financial sinks who draw huge wages and the organization cannot employ these professionals for other multiple tasks like other para medical human resources. It is also not possible for the organizations to give them a routine work schedule nor it is possible to go without them as a full time employee. Thus, this health care organization benefits by this program by making the best use of the available human resources without affecting the everyday care procedures stated in the patient care document. For example, the service of a physiotherapist is needed only when a orthopedic case comes to the point of walking during convalescence and the hospital receives only 3 such cases per month on average. Speech therapists do come into picture only in paralytic cases or Bell's palsy cases. Thus, the goals and the objectives of the Hospital is to target these elderly population so that a qualitative measure in terms of quality health care standards is available for evaluation and comparison with other health care organizations. This paves way for a qualitative assessment in terms of number of patients targeted, number of patients under treatment and number of patients



expected to be treated by canvassing customers by way of marketing and number of patients to be treated by referrals from other health care organizations. The success of the programme can be evaluated using the same qualitative and quantitative data.

### “ SWOT” ANALYSIS

SWOT Analysis, also known as TOWS analysis, in a business context is a powerful tool for understanding an organization's Strengths and Weaknesses, and for analyzing the Opportunities and Threats faced by an organization. SWOT is particularly powerful in that it can help uncover opportunities that we are well placed to take advantage of. By understanding the weaknesses of our business, we can manage and eliminate threats that would spoil our business. Using the SWOT framework, we can craft a strategy that will distinguish us from your competitors to compete successfully in the market. Strengths and weaknesses are internal factors of the organization. Opportunities and threats relate to external factors. For this reason the SWOT Analysis is also called Internal-External Analysis and the SWOT Matrix is sometimes called an IE Matrix Analysis Tool. Thus, SWOT of this program was done as follows;

Strengths: What advantages does our hospital have? What do we do better than anyone else? What unique or lowest-cost resources do we have access to? What do people in the health care segment see as our strengths?

Inference: Our Hospital has the advantage of a Brand name in The Riverside Convalescent Hospital. We already offer service in the area of Convalescence and we have targeted a segment untouched so far by the health care segment. We have access to an already existing infrastructure, which will be extended into the program. People in the health care segment do approve with our professional and ethical approach to health care.

Weaknesses: What could we improve? What should we avoid? What are people in the market likely to see as our weaknesses?

Inference: We have been a closed environment organization so far confining only to health care patients who come to us. We do not know how a care organization markets itself fully. Hence, we should avoid complacency and overconfidence. People in the market may take advantage of our first attempt and inexperience in marketing.

Opportunities: Where are the good opportunities we are facing? What are the interesting trends we are aware of?

Inference: Targeting elderly population has its own merits. Health care of elderly population demands enormous resources of time, energy and money. Hence, every family looks up to any such programs with some faith element. Care of terminally ill population is thus still more stressful for the family in a hospice setting. Any hospice setting requires a interdisciplinary care provided primarily in the home of the terminally ill patients. Such patients

are usually immobilized and it is not medically advisable to take them to a hospital for such therapies.

Threats: What obstacles do we face? What is the competition? Are the required specifications for the job, products or services changing? Is changing technology threatening our position? Do we have any bad debt or cash flow problems? Could any of our weaknesses seriously threaten our business?

Inference: Although we are stepping up into marketing health care for the first time and we have to overcome the initial inertia, fortunately we definitely have no competition in this segment of care being taken to hospice. The job specifications namely physiotherapy, occupational and speech therapy are just an extension of already existing services in the sense that they are routine medical services being offered in hospitals and palliative care units everyday. Now this service will be offered for the first time right at their home. There is no technological threat or cash flow threat with our annual turnover crossing \$6000000 in the past three years. One weakness that can spoil our business is our inexperience in marketing and proper planning and strategic implementation can take care of this aspect too. Inexperience in marketing has been due to the fact that the Hospital has been concentrating on the in-patient population who has been referred to the organization because of its reputation and services. The organization has thus so far has been a conservative care giving health care organization . It

is a mile stone event in the history of the organization to have stepped into marketing health care.

## MARKET SEGMENTATION

Market segmentation involves the identification of a fairly broad range of customers/ markets that are potentially significant to the success of our SMP. Market segmentation in our case is simple because we have a supra specific target. We target not only customers in hospice but also potential ' would be' customers in industrial hazard exposure cases. As discussed , we aim at three strata of supply chain. The supply chains will be

1. OCCUPATINAL HAZARD CASES à The Riverside Convalescent Hospital
2. HOSPICE CASES à The Riverside Convalescent Hospital
3. OCCUPATINAL HAZARD CASESà HOSPICE CASES à The Riverside Convalescent Hospital.

## MARKET TARGETING

Market Targeting is the selective ranking or deletion of the previously identified market segments into a small number of primary (most important) and secondary (less important) target markets. Market Targeting is significant in our SMP because of the fact that we are looking for a constant supply of customers for a maximum period of time. Thus, our primary target market comprises of the Hospice and Occupational hazard cases. Our secondary target market comprises of workers in their early fifties who

cannot be called elderly in the true sense but have chronic exposure levels almost near to those in the verge of retirement. This population form the second line of our target because of the fact that the probability of these workers becoming potential customers is almost cent percent-though not for terminal illness, but definitely for rehabilitative techniques .

## MARKET POSITIONING

Market Positioning identifies the features, benefits, or advantages of the program that distinguish it from the competition, and will uniquely position it in the mind of customers. This is significant in the changing health care scenario where the patient is well informed, has the right to accept or refuse a treatment, issue advance directives and even appoint a proxy directive. The unique target population, the significance of the service being taken to the patient's home, an aspect untouched so far by many health care organizations, the time constraints faced by many families in the super fast world in taking these elderly people for a regular therapy, the advantages the patients get in terms of pain relief, effective communication capacity and symptom relief shall distinguish the program from the rest of the health care programs that are currently available. There are no competitors in this area in the entire State of California and hence, our program shall be the first of its kind. As discussed the occupational hazard cases are potential hospice cases and hence our target patients have the need for speech, occupational and physiotherapy therapy in some point of time. For example, A sixty two year worker in hospice suffering from CNS breakdown needs the support of a physiotherapist and speech therapist invariably.

## MARKET STRATEGIES AND TACTICS

Market Strategies and Tactics should directly always support the Marketing Goals and Objectives and hence it is necessary to plan broadly and more specifically about how we seek to achieve them. The “4P” elements of the marketing mix namely Product, Price, Place, and Promotion is part of any marketing strategy. The product is unique and hence is self-selling without doubt. This is because of the fact that it is indeed difficult to get an appointment with a speech therapist or physiotherapist on account of their smaller number as compared to other medical professionals and the long periods of time they need to spend with a patient. The place is of course, located in one of the cash reservoir states of USA. Hence the price and promotion only matters in this case. The price need not be competitive but definitely has to be affordable to an Average American Family. Hence, it is honorable and tactical to have a price tag on par with cardiac care programmes. Promotion has to be not only informative but also educative explaining the various aspects of the background information discussed. This should include TV shows, pamphlets, News articles in popular News Papers, Seminars and Workshops. The promotional campaign asserts itself as an awareness programme.

## THE IMPLEMENTATION SCHEDULE

The Implementation Schedule is nothing but a chronological sequence of events and activities that need to be achieved over a defined period of time to achieve the Nursing Home's Goals and Objectives. This includes the

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marketing team and creating a schedule of advertising events. The marketing team will be sphere headed by a Chief Manager positioned in Chico who will be assisted by a Manager (advertising) and Manager (business). The idea of having two sections of advertising/campaigning and business separately is that the campaign and business will have to go simultaneously. Each Manager under the Chief (who is the current Chief Administrator of the hospital) will have two representatives each initially to work. Thus, both these operations run parallel . The program is scheduled to start on the September 1, 2006. The initial advertising will begin the same day on all popular media. The campaign will be of two different strategies.

1. Target the population by advertisements, pamphlets, and workshops, TV shows etc.
2. Make a search of the palliative care units in all the hospitals looking for potential hospice cases and look for records of work maintained as per OSHA stipulations in all the industries about the target populations in and around Chico.

The data fed by the campaign team will be followed up by the business team, which will call the customers, convince them and get the business. Thus, one team generates the data and the other processes them. This is expected to standardize by October 2006 when there is a big data generated and a big data in process. Thus, by December 2006, there will be a decent population of customers for the hospital to begin treatment on a regular basis from the New Year. This period is required to adjust the service hours

of the existing duty doctors and nurses. There will not be any new appointment of physiotherapists, speech therapists or nurses. The customers are expected to increase as our marketing catches up momentum.

Introduction of more professionals proportional to the customer number is not our strategy. Our strategy is to ethically and prudently utilize an underutilized professional group within the organization.

## THE CONTROL SYSTEMS

The Control Systems are the mechanisms and timeframe that will be used for feedback and evaluation of what has been accomplished. In this programme, a website will be opened for the public to post their opinion. Customers are members in the site and will have a username and password to access a separate interactive platform. The website will tell a lot about palliative care, hospice and occupational hazards. This control system will also have a 24 hr customer phone lines for them to make any enquiry and links to other health care segments to popularize the site. This website is a information site for many who are not aware of such a facility, but shall be only too glad to use the same.

## THE ORGANIZATIONAL STRUCTURE

The Organizational Structure identifies and describes the role of individuals, and their relationships in the Nursing Home, who are key to the success of the SMP. The Chief Administrative Officer will take up the additionalresponsibilityof the Chief Manager in this program. He will Plan,



Coordinate and will see the success of the program. Motivation is the key factor for individual job satisfaction and the job satisfaction of individuals leads to 'organizational commitment' and ultimately the success of an organization. Hence, the Organizational climate is planned to be Supportive, instead of Aristocratic or Custodial, which offers the workers a sense of personal importance and responsibility, thus maximizing Organizational Commitment of the employees. According to Herzberg, "work itself" motivates an individual, if he has an aptitude for the work. The team shall be a team of professionals with an aptitude for Medical sector. The campaign and business Manager will report to the Chief Manager. These two Managers are independent peers in the organization and they have a sales team of their own. The Speech, Occupational or Physiotherapists are regular employees of the hospital and they carry out their duties on the orders of the Chief Administrative Officer who is the Chief Manager of the program. These health care professionals will be assisted by Specialist Nurses when necessary. The availability and duty of these nurses will be based on the recommendations of The Chief Nurse Manager of the hospital. Thus, the Health care team and the Sales team are independent teams who execute their tasks through a central control of the Chief. This ensures the success of the program without interference on the routine medical functions of the patient care in the hospital.

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## THE MARKETING BUDGET

The Marketing Budget itemizes the salaries and other costs including facilities, supplies, services, promotion activities that are directly related to the Strategic Marketing Plan.

This may be developed taking into account the labor cost, materials like brochures, flyers, newsletters, advertising fees, printing, and admission forms, implementation costs, Mailing and postage, and a miscellaneous expense like special events, open house, educational programs, travel (gas and parking) etc. This is program, which aims at maximum out put from a minimum out put because of the unique nature of the target population. It should be understood that unlike other diseases and doctor appointments, physiotherapy needs repeat sessions; speech therapy needs repeat sessions too. Thus, every patient becomes an income generator for every session with us. Thus, our customer base multiplies like a cell multiplication where one customer is himself equivalent to many. An estimate of the expenses is summarized as follows;

1. Salary of the Chief Manager:

Does not need a salary because of the utilization of an existing position. She will be paid an additional \$1000 per month for her new responsibility.

2. Salary of the campaign/business managers:

\$ 6000 per month +benefits X 2

3. Salary of the Sales Representatives:

\$ 4000 per month +benefits X 4

4. Other expenses like brochures, flyers, newsletters, advertising fees, printing, and admission forms, implementation costs, Mailing and postage:

\$ 3500 per month

5. Miscellaneous expenses:

\$ 3500 per month

6. Professional fees for the Health care team:

Physiotherapists/occupational/speech therapists:

\$ 300 per hour paid for every patient they attend to in addition to the salary they receive from the hospital for their regular employment.

Nurses:

\$150 per hour paid for every patient they attend to in addition to the salary they receive from the hospital for their regular employment.

Therefore, a total budget of a maximum \$ 40, 000 per month. The return of the marketing budget in terms of the annual operating costs/income/net profit is promising. For an annual \$ 4, 80, 000 expenditure, the first year annual income is targeted at \$ 48, 00, 000 with a \$ 43, 20, 000 net profit.

THE CLOSING STATEMENT

This Closing Statement very briefly summarizes what we have set out to achieve. The Strategic Marketing Plan (SMP) of The Riverside Convalescent Hospital health care organization aims to target the elderly community in need of occupational, physical therapy and speech therapy in the city of Chico initially and then in the entire state of California. No other organization can provide these services easily because this service involves employment of occupational and speech therapists on a full time employment and only such organizations like The Riverside Convalescent Hospital, which concentrates on convalescent care can afford to employ such professionals full time. Hence, It is important for us to see success in Chico and establish ourselves. The program shall be implemented as per the planned schedule with due legal formalities. This is a neo concept and there is a fair chance of professional piracy. But the concept is self-selling and the target population abundant-Hence the first one to start wins by all probability. Strategic implementation of The Strategic Marketing Plan (SMP) is the key to success of the program. We are confident of capturing this segment in the entire state of California by the end of 2007.

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