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MARKETING THEORY:
APPLICABILITY TO SOCIAL WORK SERVICE PROGRAMS IN HEALTH CARE DELIVERY

by

Mary Genkins

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

1986

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the Degree of Doctor of Social Welfare.

4/14/86
date

Simon Slavin
Chairman of Examining Committee

4/14/86
date

Executive Officer

Phyllis Caroff, D.S.W.

Gary Rosenberg, Ph.D.

Simon Slavin, Ed.D.

Supervisory Committee

The City University of New York

Abstract

MARKETING THEORY:
APPLICABILITY TO SOCIAL WORK SERVICE PROGRAMS IN HEALTH CARE DELIVERY

by

Mary E. Genkins

Chairman: Professor Simon Slavin

This presentation explored the impact of chronic illness on middle and upper class health consumers; and their growing need for social health support services. It addressed social work service's engagement of a middle class population with chronic illness, and provided a descriptive analysis of a range of institutionally based private social work health care models currently operating in a major tertiary medical center.

One model, offering social work services to Myasthenia Gravis patients in a private medical setting, was studied in-depth to determine the consumer market's service needs, preferences and interest in the program. Principles of marketing and consumer utilization theories were applied to the task of assessing these factors.

Findings: Seven distinct institutionally based social work practice arrangements were identified and examined. A typology was developed to classify institutional and community based medical practices in order to determine their potential for social program development.

Drawing on a Myasthenia Gravis model, a survey analysis of prospective and existent social work consumer markets was performed. Findings showed that a potential market for social work service existed, and that private patients preferred a social work service product that resembled traditional practice in health care institutions, with some modifications. We also found that the study group was relatively unfamiliar (47%) with social work services and that 87% of the respondents wanted more information. Over 50% indicated interest in potentially utilizing the service. Analysis of service users revealed that the physician played a key role in both informing patients about the service and influencing them to utilize it.

Conclusions: The results of this study support the contention that the development of private social work service health care models represent an important new area for professional expansion. They not only offer opportunities to serve new and underattended client markets but also constitute a source of revenue to help support programs serving non-paying clienteles.

Preliminary data further suggest that application of marketing theory to social program development can result in programs that are functionally more responsive to consumers' needs and structurally designed to capture their interest and participation.

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CHAPTER I. INTRODUCTION

Application of social work services in the health field has been targeted most notably on the elderly, mentally ill, physically handicapped, members of the armed forces and veterans, and indigent populations; the incident of hospitalization and subsequent planning required for discharge and return of patients to the community. Most analyses of effectiveness, efficiency and cost of health care delivery and that of attendant social work services have, therefore, been concerned with these areas. Indeed, much of the insurance and funding strategies which have evolved over the past two decades reflect this bias of approach.

With the improved medical technology currently available, major lacunae in this type of approach are emerging. Analysis of an incident of hospitalization and the tabulation of many such incidents does not take into account the longitudinal chronology of many ailments in which the initial and secondary hospitalizations no longer have a fatal termination. The multitude of problems associated with chronicity and the by-products of medical technology, are rapidly becoming major issues in health care.

During the social progressivism period of the early 60's, medical social work became closely identified with the needs of the poor, helping this population gain access to medical care that was previously denied them. With the enactment of Medicaid and Medicare, public responsibility for financing services for the underprivileged was assumed. Today, despite greater access, this group avails themselves of medical care later in the course of illness. Consequently, it is the middle class patient, who with better and earlier availability of treatment, enjoys the benefits of improved technologies and therefore has formed an increasingly larger reservoir requiring recurrent medical services for the same illness.

Historically, social work services have not been routinely utilized by chronically ill patients treated in the private sector as an on-going complementary component to medical care. Unlike the poor, who return to hospital clinics where medical and social work follow-up are part of planned programming, the private patient has not been systematically targeted for continuous social work services by health care planners or institutions. Private social health services have existed outside of and independent of institutional settings. More recently, as professionals have become increasingly sensitized to the inter-relatedness of medical and social needs, there have emerged some beginning efforts toward making institutional based social support services available to these patient groups. These developing efforts coincide with the social work profession's own needs to develop new client markets and expanded roles in response to the financial cutbacks and fiscal restraints resulting from declining governmental and philanthropic funding of human service programs.

This project will address social work service's engagement of a middle class population with chronic illness and assess the design and development of currently operative service delivery models from a consumer oriented marketing perspective. It will thus apply a theoretical framework to social program planning that is employed by the for-profit business sector and is concerned with designing and defining an organization's service in terms of the target market's needs, perceptions and preferences. Such an approach seeks to maximize consumer response, acceptance and participation and thus enhance the chances of program success. Because it can result in more effective "client oriented" service, this methodology has relevance and applicability for all social health consumer classes and groups treated in a variety of private and clinic settings. It is thus in keeping with the values and norms which guide the service delivery principles of the social work profession.

Chapter 2 of this project will analyze current health care policies, discuss existing approaches and focus on the problems posed by the growing pool of middle class patients with chronic diseases that require prolonged medical care. The impact of this problem at an individual, familial and societal level will be explored. Presently emerging social work service delivery models and those from an earlier era will be examined for their relevance and contributions to current and future social health planning in this programmatic area.

Chapter 3 will present a theoretical frame of reference for the dissertation project. Principles of marketing and related theories of consumer utilization will be discussed with particular focus on factors affecting market demand and response to human service and health care programs.

Chapter 4 will address the design and plan for implementation of a project which focuses on the social work service delivery models pioneered at The Mount Sinai Medical Center (New York). These models have begun, to varying degrees, to involve chronically ill, middle class patients treated in the private sector, on a fee-for-service basis.

One model, offering social work services to a chronically ill population of Myasthenia Gravis patients, will be studied in-depth to determine the consumer market's service needs, preferences, and interest in the program. A strategy for marketing private social work health care programs will be developed. A central component of this project is the design of an instrument to identify consumer preferences and assess factors affecting their acceptance and utilization of these service approaches.

Chapter 5 will evaluate the results of the consumer analysis survey study and provide a descriptive analysis of the range of private, fee-for-service social work models currently operating in the Medical Center. Chapter 6 will look at implications for private model development and discuss recommendations for the application of marketing theory to social work service program planning in the health care field, based on conclusions drawn from this study.

CHAPTER II. BACKGROUND OF THE PROBLEM AND REVIEW OF SERVICE DELIVERY APPROACHES

A. THE PROBLEM

Major achievements in biomedical technology over the past few decades have had a profound effect on middle and upper income health consumers suffering from chronic illness. Improvements in ability to sustain and maintain an ever increasing number of these patients will require the design and expansion of support systems for population groups not previously identified as needing the services of social health planners and providers.

This group consists of patients who are treated in the private medical sector and who represent a high proportion of the survivors of incurable illness. It has been shown that, despite greater access to and utilization of medical services by the poor, they tend to avail themselves of treatment in the latter stages of the disease process.[1,2,3,4] There continues to be significant differences in average survival rates for upper and lower classes in the major chronic disease groups; especially in cancer, cirrhosis of the liver, hypertension and emphysema.[5] Consequently, the surviving beneficiaries of technological advances consist more and more of the middle and upper class populations who have better integrated themselves into the health care delivery system. Even this class, given the spiraling cost of medical treatment and loss of productive work days can no longer bear the financial and social expenses that accompany prolonged illness. Furthermore, from a national health cost perspective, the chronically ill are costly users of medical care, requiring repeated hospitalizations and life time maintenance. They unquestionably consume a high percentage of the health care dollar.[6]

Traditionally, the physician has had the primary responsibility for the care of privately treated chronically ill patients. However, question has been raised as to whether the social stresses associated with prolonged illness in terms of financial strain, loss of functioning and psychological impact on patient and family can or should be managed solely by the physician-specialist.[7] Although an integrative approach which addresses the psychosocial as well as medical components of care would seem desirable, very little in the way of programmatic planning in this direction has been attempted. The reasons for this appear to be three-fold:

1. National health policy has predominantly concerned itself with meeting the comprehensive health requirements of lower socioeconomic groups; to a large extent focusing attention away from the needs of the other social groups. Financial support has been targeted at the growth and development of biomedical technology, to the detriment of services which are aimed at facilitating adaptation to long term illness.
2. Efforts to secure third party coverage for clinical social work services have met with limited success. In recent years, the profession has accelerated its efforts to broaden insurance coverage for social work services. However, while 35 states have enacted licensure laws regulating social work practice (which is a prerequesite to vendorship legislation), only 14 states to date, have extended vendorship rights to clinical social workers, enabling them to be reimbursed as qualified

providers under insurance policies with mental health coverage.[8] Restriction on reimbursement is a deterrent to program expansion in the private sector.

3. The major medical agencies with which social work in health care is associated have been hospitals and clinics; the majority of clients being of lower socioeconomic background. There is, as yet, relatively little formal association with private medical practitioners and middle income patients which extends beyond hospital setting.[9]

Thus, there exists a group whose social health needs have largely been underserved by policy makers, health planners and medical social work practitioners.

The following sections explore this issue in greater depth as follows:

1. An analysis of social health policy; its impact on the structure of the current health care delivery system.

2. A discussion of chronic illness in a disease-specific population and as it relates to broader societal issues.

3. An examination of social work service delivery in the private sector: a nonphilanthropic agency serving middle and upper income clients; social work practice models in private medical settings; social work health care practice in the private medical sector under hospital based auspices.

SOCIAL POLICY AND THE HEALTH CARE DELIVERY SYSTEM

The cumulative effect of past political, social, economic and technological forces has brought us to a point where funding mechanisms are inadequate to support the spiraling cost of medical care, as are provisions for helping the growing numbers of chronically ill and disabled patients adapt to or overcome the financial and social demands of illness. Costs are clearly exceeding the amount people wish to pay for medical care.

A fallacy in original policy design is what Wildavsky calls "The Great Equation": medical care = health.[10] This major miscalculation failed to take into account the psychological, social and cultural factors that, along with medical treatment, constitute the sum parts of holistic health care. Analysts tend to agree that particular policy outcomes are often the result of the interplay between policy design and institutional settings.[11] Because the medical profession, and in particular academic medicine, dominated the political process; efforts were targeted at supporting an acute, curative hospital based system.[12] The guiding assumption was that health could be achieved through access to medical care. Implicit faith in the ability to cure through science placed unrealistic demands on the role and function of physicians, led to the financing and organization of a health care structure that encouraged medical technological advances; largely ignoring the social health factors of illness, and created inflationary costs resulting from heightened public expectations and expanded utilization of resources.

Critics and analysts have now begun to recognize the ethical dilemmas and mounting problems which must be faced in the coming decade. As Merlin Duval points out:

> "We will soon no longer enjoy the unlimited resources that have hitherto allowed us to avoid having to make truly difficult decisions. Choices will have to be made between pursuing higher forms of technology designed to prevent disease and rehabilitating those citizens who are already afflicted with chronic illness. Most factors that bear on our health lie outside the control of traditional medicine... we must either educate health professionals to include social and economic factors that bear on health or separate those factors more clearly from the medical domain."[13]

A flaw in policy and program design was the failure to recognize or estimate the important role psychosocial factors play in determining health status at the collective or individual level. Past successes and failures have created new needs which require a restructuring of services. The aim of application of high technology was to save life but little thought or programmatic planning was given to the maintenance and quality of such life -or to the impact of the initial decision on the individual, family and society.

The health care industry is now embarking on an era that must forge the linkages between medical treatment and social health care. Under the present political climate, service delivery designs must include features which render high quality care, economic viability, and the preservation of patient and family stability, particularly in those groups affected by prolonged and chronic illness.

CHRONIC ILLNESS

General Characteristics

The elimination of infectious diseases as the leading cause of death has left us to deal with the chronic disorders. As defined by the Commission on Chronic Illness "chronic illness is an impairment of health that requires an extended period of medical supervision."[14] Chronic illnesses are not, as often thought, diseases of old age but frequently occur between the ages of 15 and 64 and reportedly affect 65% of the American public.[15,16] Care of such patients takes place in ambulatory or institutional settings, private homes and acute care hospitals. The illness can be manifestly disabling, progressive or stationary. Disability results from an impairment of the biological, physiological and social efficiency of the individual and prevents him from pursuing normal or usual activities.[17]

Myasthenia Gravis (MG): A Bio-psychosocial Profile

MG is chosen as a prototypical example of a chronic illness that requires multiple adaptations by patients and families. Although some of its symptoms are unique, the resultant disabilities and stresses are common to other chronic diseases. It clearly illustrates the psychosocial aspects of illness and their relationship to physical incapacitation and variability of symptoms. It is particularly relevant as it is one of the few medical areas that has been selected for hospital social work intervention in the private medical sector. The project presently in progress, is being conducted by the Mount Sinai Medical Center in New York City and will constitute the primary focus of the dissertation research study.

Description of Illness

Myasthenia Gravis is a neuromuscular condition characterized by abnormal fatigability upon repetitive use of muscles under voluntary control. These muscles are partially repaired by rest and anticholinesterase medication. Symptoms are dependent upon the particular muscle group involved.

Respiratory distress can be severe and require the use of ancillary breathing devices. Skeletal muscles are affected, particularly those of the neck, shoulder, girdle and hip; and atrophy in selected areas is not uncommon. Myasthenics also experience pain and discomfort which is usually brought on by prolonged use and exertion of muscle groups.

MG has an occurrence rate of 1/20,000 and affects all ages, sexes, races and economic groups. In general, there is little evidence to support any genetic determinant in MG; the predominant rate occurs in the third decade of adulthood. While MG is fundamentally a progressive disease, there are cases when symptoms remain localized, e.g., ocular myasthenia. More often though, it appears to be generalized and runs an erratic course ranging from mild muscular involvement with good drug response to the more severe forms where there is a high rate of crisis and mortality.

MG cannot be reproduced in laboratory animals and at present no known cause or cure exists. Recent advances in the diagnostic, therapeutic and clinical aspects of the disease have, however, had a significant impact on prognosis and symptom management.[18]

Medical Aspects

Early misdiagnosis is a common problem in this disease and creates major social problems for patients and their families. The ignorance of the medical profession coupled with a paucity of available care results in patients being repeatedly mishandled - at great economic and emotional cost. In addition to the need for educating the medical profession, patients are concerned about their own education and increased ability to handle their illness. Many feel that because doctors don't understand enough about MG, they often impart a sense of hopelessness to patients and tend to underestimate the capabilities of myasthenics.

Once a patient comes into an appropriate treatment setting, problems can arise around continuity of care in terms of professional cooperation and communication. The nature of the illness requires input from surgery and cardiology in addition to the neurologists who normally direct primary care. Whenever a myasthenic enters the hospital it necessitates multi-system collaboration and the involvement of numerous personnel and specializations. The situation can become further complicated by the fact that there currently exists within the medical profession diverse schools of thought and practice with regard to treatment and management of MG.

The difficulties surrounding quality and availability of care constitute a major patient concern, however, there also exists a number of demands that relate to the patient's role in the treatment process. The primary means of symptom control involves the use of drugs. However, the dosage varies from patient to patient and can vary in the same patient from day to day. Overdosage of a particular drug can have the same effect as underdosage and the patient must become responsible for regulating his medication and judging its effects. While in fact there does not appear to be a correlation between amount of medication taken and severity of illness, patients often respond to drug variations with anxiety and fear. Chafetz points out that increasing medication makes the patient afraid he is getting worse; decreasing the medication raises the spectre that the lessened amount will not control the symptoms.[19]

Hospitalization is a certainty for most myasthenics. In cases where the disease assumes a more severe form, hospitalization can occur at the point of diagnosis for purposes of observing drug reaction and determining extensiveness of muscle involvement. In the course of MG, the most dramatic and critical event is the "myasthenia crisis" or respiratory failure. Crisis can be brought on by infection, emotional trauma, insufficient or overdosage of medication. If unattended crisis can result in cardiorespiratory collapse and death. At the onset crisis requires emergency hospitalization, usually in an ICU where specially trained personnel perform medical and surgical procedures to relieve distress. During periods of hospitalization, whether it be for emergency treatment or on an elective basis, the medical procedures involved in treatment do, for a limited time, cause an increase in symptoms and render the patient severely ill and totally helpless. For this reason patients experience a great deal of stress before and during hospitalization and for some, it is viewed as life threatening.[20]

Reaction to Diagnosis

Reaction to diagnosis is closely tied in with the patient's concept of his illness.[21] Because MG is relatively unknown to the lay public, a patient's initial reaction may be misleading. Martin and Flegenheimer discovered that patients almost inevitably expressed relief upon hearing a label applied to their symptoms.[22] As mentioned earlier, diagnosis frequently occurs after the long unsettling experience of trial and error. Brolley and Hollender felt that patients showed mild reactions to diagnosis because the unfamiliar name of the disease bore no impact (in contrast to cancer or TB).[23] As patients begin to integrate the implications of the illness - that it is chronic, treatable but not curable, medication is taken indefinitely - and experience physical distress, their outlooks and coping mechanisms may drastically change. The subjective and cultural meaning of weakness, dependency and physical impairment vary from patient to patient and clearly can be influenced by environmental factors.

Self Esteem

The unpredictable nature of MG - both in terms of everyday functioning and long range prognosis, poses a constant threat to self esteem. When a myasthenic is feeling well, i.e., relatively asymptomatic, he regains a sense of physical fitness, self sufficiency and autonomy. Problems arise with the reappearance of symptoms and concomitant loss of independence. The patients experience a narcissistic trauma and conflict is renewed at an intrapsychic as well as interpersonal level. These periodic changes in status, which affect role relationships and undermine self-confidence, often lead to apathy, isolation and inhibition of social functioning.[24]

Body Image

Physical alterations of body image occur quite frequently in MG; particularly changes of a facial nature. Drooping eyelids (ptosis) and constrictions of the upper lip often cause myasthenics to appear stone-faced and sleepy. Inability to smile or frown coupled with a decrease in voice volume and clarity inhibits expressiveness and restricts two-person communication. Many myasthenics find this condition socially inhibiting - especially young adults and adolescents.

The ways in which patients compensate for bodily changes can be functional or dysfunctional depending on whether or not they are appropriately integrated into the ego.

Influence of Emotion

As happens in any chronic illness, the myasthenic will experience emotional reactions to his illness that are common and predictable. However, in MG emotion plays a significant role with respect to increased muscle weakness.

Chafetz sees a correlation between emotional upset and the onset of illness.[25] Meyer states that psychic stress can aggravate and exacerbate symptoms.[26] While expression of affective impulses at either end of the spectrum seem to contribute to muscle weakness, anger and hostility are singled out as having a definite adverse effect. Because patients are aware of this phenomenon there is a conscious attempt on their part to suppress these feelings; at such times depression is likely to occur.

Depressions in MG appear to be of a reactive nature and are most intense when anticipated improvement does not occur, or when the patient observes that his condition is worsening.[27] Treating depressions in MG is difficult, especially in hospitalized patients who are unable to speak and must rely on written communication.

Family Reactions

MG places severe burdens on families. Unpredictable clinical fluctuations in the disease often create suspicion about the patient's degree of illness and ability to function. Unsympathetic reactions from family members will result in stress and worsen symptoms.

Children and spouses must adopt a new perspective of the ill family member and this requires difficult adjustments on their part. At the same time, the patient experiences threats to his/her roles and statuses which have become altered by limited physical abilities. A husband may be threatened by changes in occupational status and the fact that he has to assume a dependent position in the sex act. A wife may feel inadequate because she cannot fully manage care-taking responsibilities and has undergone physical changes which affect her attractiveness. Internal adjustments are complicated by feelings of guilt, dependency and resentment. Previously unresolved family problems become exacerbated by the additional component of the illness.

External factors such as availability of care and frequent hospitalizations or visits to clinics may have a severe impact on a family's life style. The fear of a respiratory crisis can color reactions and inhibit family routines and planning. Vacations are put off or cancelled; sometimes families have relocated to be near a doctor or hospital. Furthermore, home care for the patient is essential and often requires that family members undertake performing difficult and sometimes unpleasant medical procedures.

Finally, the financial cost of MG is a severe hardship. Even with adequate insurance coverage, most families carry exacting financial burdens which significantly add to their existent stress and anxiety.

Cost Factors and Chronic Illness

From a societal, as well as individual point of view, chronic illness represents a major social problem in terms of out-of-pocket expenditures for medical care treatment and insurance coverage, loss of productive workdays, and erosion of the tax base resulting from deductions for large medical expenses not covered by third party payments.

With respect to insurance coverage for major illness, Birnbaum points out that:

> "although the middle-income groups are moderately well protected by insurance coverage, the benefit structure of private insurance is far from universal; policies are characterized by exclusions, restrictions and limitations... even with recently expanded benefit levels, policies do not guarantee full coverage of large out-of-pocket expenditures. Physician services are not fully covered; and nursing home and psychiatric care are available to only a minority of the middle income group covered by private insurance."[28]

In addition to the financial considerations already mentioned, there is new data emerging which show that the highest cost users of medical care and health resources are those patients who are repeatedly hospitalized for treatment of the same disease. "Reduction of mortality from severe or chronic illness lengthens the average duration of the illness and increases its frequency in the total population. Over time, their repeated hospitalizations for the same disease can be extremely demanding of medical resources. The maintained treatment posture (with neither cure or death) is a remarkable cost multiplier of national health costs."[29] In his article, Zook notes that readmission for patients with long-term illness are above average in both duration and unit cost. He also establishes a link between the high rate of readmission for the same illness and the personal habits and lifestyle factors of these particular patients.

"Hospital recidivism", according to Zook, has major implications for public health policy. If one can identify the high cost groups of "repeater patients" with particular illnesses, then public health policies can focus on these groups for the purpose of achieving economies, e.g., vigorous follow-up and increased medical compliance can potentially reduce hospital admissions. In addition, financial incentives in health insurance could be structured to discourage costly hospital readmissions if preventive programs and low cost alternatives were made available.

The data in Zook's study suggest that the costs of long term illness are higher than previously thought and are increasing over time. It also points out the prior research which has focused on catastrophic illness as the major health resource consumer may have obscured the fact that chronic patients with short stay, repeated hospitalizations are actually the dominant high cost group. Both acute care hospitals and third party payers view the patient with sudden traumatic illness as constituting the most expensive user of care. Health insurance continues to emphasize hospital and surgical expenses. Coverage is less extensive, in order of decreasing magnitude, for regular medical expenses, ambulatory care... psychiatric care, home health supports and preventive care.[30] However, the wisdom of these policies is now being questioned. For example, under the Diagnostic Related Groups (DRG) system, there are incentives to limit hospital stays and allocate resources for providing ambulatory, preventive, and supportive services to help maintain patients in the community or in less costly treatment facilities. In light of new data and recent policy shifts, more intensive investigation of chronically ill population groups would seem indicated in order to better understand the causes of medical recidivism and ultimately reduce its prevalence in society.

Support Services for the Chronically Ill

As indicated in Zook's work, there is need to enhance our understanding of the longitudinal aspects of chronic illness in order to uncover patterns, behaviors and environmental stresses which result in the use or overuse of expensive medical resources. Despite the relevance of such information for program planning, efforts in this direction have been scanty, leaving a significant gap in our knowledge base.

As presently constituted, the health care system is designed to deal with specific incidents of illness; little in the way of manpower or resources are available for on-going surveillance and maintenance of patients during non-critical periods. Long term follow-up is a problem with which health professionals continuously struggle. Social workers in hospital settings have limited contact with patients following discharge; especially those treated in the private sector. Even in outpatient clinic settings, comprehensive longitudinal follow-up is difficult to achieve with the exception of some tertiary clinics where funding and regular patient visits make it possible. Lack of systematic follow-up not only precludes the possibility of identifying the multi-dimensional factors associated with chronic illness, but also prevents these patients and their families from receiving the necessary support needed to maximize their functional capacities.

A study conducted a number of years ago by Donabedian and Rosenfeld sought to determine the kinds of problems chronically ill patients encounter; their requirements for on-going supports and services after they are discharged from hospitals.[31] The study group consisted of 82 elderly patients, with limited financial resources, who were moderately to severely disabled as a result of chronic illness. Each patient was given a medical regimen to follow, referrals to appropriate community agencies and was selected for social work follow-up visits at the end of three months.

The findings are worth noting:

- In under three months time almost one half of the patients were readmitted to some kind of institution.
- Fifty-eight percent of the male patients who were employed prior to their hospitalization could not regain employment.
- While there was heavy use made of caretaking agencies in the community, there was infrequent use of social work and Visiting Nurse Services despite a prevalence of severe social and physical handicaps.
- More than half the patients did not comply with one or more of their physician's recommendations - (no attempt was made to explore the motivating reasons).
- Patients were queried as to services they considered necessary, but did not obtain. Social service was the most prevalent and included requests for financial assistance, information, education, reassurances, suitable employment, transportation and household help.

The results of the study underscored the fact that, for many chronically ill patients, any one hospital admission is only an episode in the disease process. Much of what has been gained during hospitalization was lost in the post-hospital period, as those patients generally lacked the mechanisms to adapt to the complex social and physical demands imposed by illness. Lack of continuity of care was cited as a major deterrent to maintaining stability and improvements. Particular mention was made of the need to perform a "social diagnosis" in order to firmly establish whether on-going supervision and support is warranted. No specific suggestions for funding after-care programs were included. While the authors discussed the important role social work would play in such endeavors, the private physician was singled out as the person who should assume responsibility for long term supervision and for obtaining and coordinating the services of community agencies to aid his patients.

This study, as others,[32] connects the high rate of hospital utilization among the chronically ill to a lack of continuity of care and comprehensive follow-up - particularly in the immediate post-hospital period when patients are most vulnerable.

In the decades following these studies, there has been a growing awareness on the part of social health planners of the on-going needs of patients subsequent to discharge; accompanied by rapid growth and adoption of discharge planning programs by hospital social work service departments. However, despite efforts to alleviate the problem there continues to exist serious gaps in comprehensive service delivery and follow-up. A recent study by Lindenberg and Coulton demonstrated that although required services for chronically ill patients were recognized and planned for by hospital social workers prior to discharge, a substantial number of the patients did not adequately have their social health needs met once they returned to the community.[33] Clearly, in the two decades that have passed between the Donabedian and Coulton studies, the trends, issues and problems concerning comprehensive planning have not markedly changed; institutionally-based services have not significantly transcended the boundaries of the hospital setting to adequately meet patients' needs in the community.

These study findings indicate that discharge planning efforts are not far reaching enough because, given present financing mechanisms, hospitals cannot allocate sufficient funds or social work manpower to follow patients who are no longer receiving institutional medical services. Similarly, it appears that community agencies have not, as yet, adequately developed special programs to reach greater numbers of chronically ill patients and their families. In light of these findings it would seem that planning must be aimed at providing better continuity of care and at establishing stronger service network linkages among hospital social work departments, community based agencies, and private physicians.

In addition to the needs of hospitalized chronically ill patients, the social health care requirements of nonhospitalized persons with long term illness have also been examined. Studies concerning the social problems of nonhospitalized chronically ill patients have found that these patients have multiple needs which are not adequately being met by either themselves, their families or the community. Braham et al. discovered that among a group of privately treated multiple sclerosis patients with minimal to severe disability, the highest number of social needs was in the category of social casework, and that a striking number of these were unmet.[34] Among the problems requiring professional attention were patient and spouse reaction to illness, marital strain, child behavior, financial assistance, household help, and social isolation. While the involvement of various professionals was thought to be vital in meeting the full range of patient and family needs, the case worker was cited as being the logical key person to give direct supportive help and coordinate the required additional professional and agency services. The authors note, however, that persons treated in the private medical sector have an even more remote chance of having their social needs properly assessed and met due to their inaccessibility to social work. They point out that the privately cared for patient is handicapped in receiving appropriate services unless his physician is sensitive to perceiving social needs and has the time and expertise to actualize a referral.

The preceding studies emphasize the importance of making social work health care programs available and accessible to chronically ill persons not only at the point of hospitalization but also in the community. This is a vital step toward insuring effective and responsible service delivery. In addition, these studies raise the question of whether social health care programs, targeted at alleviating environmental stress and encouraging better management of illness, might not reduce the frequency of hospital readmissions, prevent further deterioration of the family and patient, and thus show a high benefit return for dollars invested.

B. SOCIAL WORK PRACTICE IN THE PRIVATE SECTOR

Despite considerable documentation which draws attention to both the growing demands for psychosocial supports among chronically ill patients and the unacceptably high individual and societal costs associated with disability, there continues to be a serious lag in the provision of services to these afflicted groups. As noted earlier, this is especially true for the middle class patient treated in the private sector who, unlike clinic patients with easy accessibility to hospital based social workers where service programs exist, has not been systematically targeted for continuous social work services.

In general, social work intervention with middle class consumers in the private sector is the subject of a limited and finite body of literature. Three social service delivery models representing different programmatic approaches to the middle income consumer market have been selected for discussion in this section. They represent the past and current range of program practice models available to upper income health consumers in the private marketplace. The models were selected because of their relationship to this study's focus which is the application of marketing principles to social work program development. When analyzed from a marketing perspective, they exemplify the complex interaction of marketing factors (product, price, place, promotion) and program features.

The first model is the Arthur Lehman Counseling Service, a nonphilanthropic, fee-for-service social work agency which successfully engaged middle and upper income clients. The second concerns social work practice arrangements in private medical settings. The third are model types of very recent vintage which combine both agency based and entrepreneurial features of practice. The prototypes of these models, pioneered at the Mount Sinai Medical Center in New York, offer social work services to chronically ill, middle income groups in both hospital and private medical office settings.

The Arthur Lehman Counseling Service (ALCS)

The ALCS,[35] under the direction of Ruth Fizdale, was a pioneering endeavor that challenged fundamental concepts about the role and mission of the social work profession and provided the framework for future designs and implementation of fee-for-service program models. Miss Fizdale's book, Social Agency Structure and Accountability, recounting the twenty year experience of a nonphilanthropic social agency which began in the mid 50's, acts as a lightening rod picking up and conducting the twin themes of open market competition and legitimation of casework as a professional discipline for middle and upper income clients. Both of these thematic issues have become the subject of many subsequent intraprofessional debates. In line with this, one can hypothesize that because of its departure from traditional social work norms, the intrinsic value and substantial accomplishments of the Lehman project with respect to innovative program design, enhancement of professional credibility and establishment of an unprecedented standard of excellence in casework competence and skill have not received the attention or recognition they merit. Few articles refer to the project; Miss Fizdale's book, written in 1974, has been out of print for some time.

Failure to promote the program's concepts may have been primarily due to the fact that its time frame paralleled the peak of the social action period when the profession intensified its efforts to champion the causes of the disadvantaged. The re-definition of social workers as not merely "do-gooders", but as skilled members of an emerging profession; the step away from total identification with economically disadvantaged populations, philanthropic purposes and institutional settings; the ability to seek out and attract a new clientele segment who could and would utilize social casework and pay full cost for service, were innovative ideas which failed to expand to other social agencies or gain professional acceptance. The one exception was medical social work. Miss Fizdale recalls, "Medical social work departments wanted advice on how to attract potential clients. Perhaps this is because medical social work comes in direct contact with an economic cross-section of the community and has the direct experience of seeing that illness creates problems for patients and their families regardless of economic status."[36]

Over time, the philanthropic purpose of social work came to be challenged. Governmental involvement in social agencies brought to light the notion that service was not only for the underprivileged but rather a right of all citizens in a democratic system. Miss Fizdale held with this philosophical point of view "all persons have identical human needs regardless of socioeconomic status and a variety of services is required to meet these needs. The socioeconomic status may determine which type of social service the client needs... primarily economic or not but these have come to be recognized as a matter of citizens' rights".[37]

The problem of reconciling diverse professional points of view, choosing between social action and social casework or the needs of the poor versus those of the middle and upper classes will merit careful consideration as we seek to achieve self-supporting programs which neither create a financial burden for the community nor are solely dependent on public and private sponsorship for their development and continuation.

With the financial constraints that are becoming apparent in this and subsequent decades, implementation of human service programs which will have the greatest cost effectiveness and best delivery of care are assuming the highest priority. For this reason, it is appropriate to re-examine the design of the Lehman project as its administrative structure, policies and procedures are remarkably applicable to program development in this social time period.

ALCS grew out of a pilot study, undertaken on behalf of the social work profession, which had the objective of reaching and serving a clientele (middle and upper income groups) that had not previously availed themselves of social work services. In the course of making the transition from a pilot program, initially grant subsidized, to a self-funding agency, ALCS dealt with a range of issues that ultimately produced a viable structural design. A select number of these which have practical applicability and are original in their conceptualization will be considered here.

Price

The underlying assumption was to test social work in an open marketplace; thereby competing with other traditionally higher paid mental health professionals. A nonphilanthropic fee was established which was based on actual cost. The unit of service cost was the interview. Factors which determined full cost were actual costs (housing, staffing, consultations, etc.), productivity (number of interviews per practitioner and size of staff), fee collection (anticipated unpaid patient bills).

In keeping with the nonphilanthropic character of the agency all fees were identical for clients; payment was expected and dealt with as a therapeutic issue. After 1961, when grant support ended, fees covered full cost and self support was achieved without diminishing capacity to maintain adequate and competitive staff salaries and quality in-service training. Two major factors contributing to success in achieving full agency support from fees were the ability to determine unit costs and maintain a high level of practitioner productivity without compromising service quality. The program's dependence on client support as a source of income made client satisfaction with professional competence a key issue.

Consumer Market

ALCS clients were generally well educated, economically advantaged and predominantly in professional or highly technical occupations. Over a third had sought previous help from psychiatry and more than half had not sought help from any source.

Place and Promotion

Clients chose ALCS for a variety of reasons: experienced practitioners, advanced knowledge of fees, trusted source of referral, expectation of immediate and continuous service with the same practitioner. Promotional materials were sent to community leaders who referred their constituents for service. In addition, presentations were given in private schools and to professional groups, e.g., lawyers, clergymen, and physicians.

The agency was reputed to have high caliber practitioners, a set fee and prompt service in a setting that was acceptable to its clientele (a residential area on the Upper East Side of Manhattan). Physicians referred because they saw the agency's procedures as consistent with private practice; the set fee and quality of staff were important considerations.

Product Features

The statistics on client utilization indicate that ALCS functioned as a typical social agency offering short term counseling, long term therapy and concrete services. Many of the requests from clients centered around the need for locating resources for aged and ill adult family members, or children with psychological disturbances and learning disabilities. The experience with clients and the types of problems presented demonstrated that upper income groups needed help and would make use of social work skills if they were made available to them.

The discussion of ALCS was primarily concerned with establishing a precedence for offering social work services to upper income groups and examining the broader programmatic implications of a successfully marketed fee-for-service model. The material that follows focuses on social work practice models in private medical settings - a relatively untested and newly developed area for professional expansion.

Social Work in Private Medical Settings

In general, the literature concerning social work in private medical settings is underdeveloped and limited to descriptive practice studies. Most examples deal with physicians in private or group practice who have hired social workers.

Place and Promotion

Social workers are employed in a range of medical settings - private clinics, group practices, primary health care programs, solo and partnership practices which represent diverse medical specializations. They are included in these medical practices for a variety of reasons. Among those most commonly cited are: the recognition that emotional and socioeconomic factors can complicate physical problems, [36] treatment of emotional stress makes patients more amenable to medical treatment,[37] inclusion of a social worker frees up more productive time for physicians by devolving them of patient counseling activities and enabling them to concentrate more exclusively on the physical components of care.[38,39] While these claims appear to have value, none of them have been substantiated.

In almost every case where the experience was reported as being a successful association, the physician had initiated the idea of a working arrangement, was knowledgeable about the role and function of social work and had had previous positive experience with social workers, usually during training.[40-42] The social workers in these practices were solely dependent on the physicians for referrals; physician acceptance was an essential condition for promoting the service with consumers.

Product Features

The types of service and interventions offered by the workers varied from practice to practice. Some of their interventions resembled conventional medical social work, focusing on the impact of illness on patients and families. Others used a broader framework employing traditional family and marital treatment, adolescent (adjustment) group work, vocational counseling; thus acquiring more of a family service orientation. Many workers indicated that patients more readily accepted referrals when encouraged to do so by their physicians. This infers that the physician's recommendation or "endorsement" may be a key factor in marketing the service to consumers.

Price

In addition to varied service patterns, there were a number of different approaches to pricing. The patient populations were of middle class social and economic backgrounds; most had health insurance, but it did not usually cover social work services. In one case fees were established by the social worker and collected by the medical office which retained a percentage to cover the overhead costs of the worker.[43] Another worker, who dealt primarily with an elderly population, received limited amounts under Title XVIII and XIX, some third party support from local governments, public charities and institutions and some direct payment from patients.[44] One demonstration project was funded by a state health service bureau. The author noted that fee setting and third party payments were unresolved problems which were identified in the project. She suggested that because of the range of services inherent in social work practice, fee setting should not follow the psychiatric model but rather the legal profession's time allocation system.[45]

A survey of ambulatory medical/social work projects[46] found that the majority of social workers in family practice settings charge fees which are established at an hourly rate and are offered on a sliding scale depending on the patient's ability to pay. It remains unclear whether these projects achieved break even functioning because the services appeared to be priced on an arbitrary rather than cost-related basis.

The data offered in these articles raises a number of questions. While comprehensive care is frequently cited as a rationale for joint social work/medical practice, there is little attention to continuity of care. No examples are offered of programmatic attempts to establish hospital-home-private office linkages. In every case the social workers were independent practitioners with no institutional affiliations. Pediatrics and OB-GYN were the only practices where there was an explicit association between the interventive activities of the workers and the medical problems of the patients.[47,48] In addition, most authors reported positive patient acceptance of social workers, but it remains unclear as to how the patients utilized these services; conclusions regarding outcomes could not be drawn.

Repeatedly, authors referred to the unquestionable authority of the physician. While this is understandable under these circumstances, it has implications for autonomous, self-directed social work practice. To what degree the physicians influenced social work practice was not determined. On the other hand, collaboration with respect to consistent feedback and exchange of information between the disciplines was not explicitly identified as an integral component of the practice arrangements.

Finally, there is the issue of fees and third party reimbursement. Hookey notes that in fee-for-service settings, a physician's assessment of the viability of a proposed collaborative arrangement may turn on whether or not his patients will be able to claim health insurance reimbursement for social work services.[49] Twersky and Cole concur and offer the opinion that insurance coverage for social work is a measure of the degree to which fee-for-service is accepted in the medical care of patients and an influence on the extent to which social workers are used.[50] It would thus seem that availability of third party coverage is becoming an increasingly important factor in the successful marketing of social work practice in the private medical sector.

Private Social Work Practice Under Hospital-based Auspices

In recent years, the Mount Sinai Medical Center, most predominantly among other hospitals, instituted a number of clinical social work projects which were based on a collaborative social work/medical model and offered comprehensive service to private patients on a fee-for-service basis. These unique types of practice arrangements represent the newest and perhaps most promising direction for service delivery for the following reasons:

- they address the social health needs of underattended patient groups
- have potential for incorporating quality assurance mechanisms for maintaining acceptable standards of practice and professional accountability
- aspire to be self funding on a fee-for-service basis
- employ an integrated bio-psychosocial approach to care

One of the central aims of these projects has been to identify patient populations who have not previously defined themselves or have not been defined as potential social work consumers and, in the case of chronically ill patient groups, to develop a model which will offer longitudinal care on a continuum from presentation to hospitalization and return to the community. The intent is to demonstrate the effectiveness of social work with a new type of client market and broaden the scope of hospital-based social work departments to include formalized associations with medical practitioners in the private sector. As such, there is an implicit recognition of the contributions of both providers and consumers in determining health care needs and assessing the relative benefits of services provided.

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This chapter explored the impact of chronic illness, at the macro and micro levels, on middle and upper socioeconomic health consumer groups. Examination of the problems experienced by these patients brought to light the need for social health counseling and support service programs that offer coordinated, comprehensive care on a continuum in hospitals, physicians' offices and community settings.

Despite its limitations, the social work profession has had a rich tradition in the private sector and is accelerating its efforts to establish programs and secure vendorship status so that it can meet the needs of private chronically ill health consumers, more effectively than in the past.

In line with this effort, new program designs are emerging which will have to compete for consumer participation with other mental health professions in the open marketplace. Analysis of past and current fee-for-service social work program models demonstrates that they lend themselves to a marketing-type of analogy and are suitable for application of marketing principles and strategies. This can serve to enhance social program effectiveness in terms of service delivery and interprofessional competition.

Among the most promising of the recently developed program designs are the institutionally based private social work practice models. To date, there is little known about the design, implementation and consumer market structures of these projects; how these factors interact to affect utilization and market appeal. Analysis of these central issues, along with the development of a strategy for marketing such programs will be the subject of the succeeding chapters of this study.

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CHAPTER III. THEORETICAL FRAMES OF REFERENCE

Introduction

This project will study the range of private social work service delivery models developed at the Mount Sinai Medical Center (NY). These program models have, to varying degrees, begun to involve the chronically ill middle class patient treated in the private medical sector. The project will offer a strategy for evaluating and enhancing a program's appeal and acceptance among its various constituent markets.

Departing from traditional approaches to program study and analysis in social work health care delivery, it is proposed to utilize theoretical frameworks that are associated with conventional business practices. The orientation of this project and its approach to programming relates not only to enhancing the effectiveness of service but is also shaped by a belief and conviction that the profession must actively seek out ways to expand its client markets and funding sources in order to offset the impact of diminishing public and private support of its programs.

Using the Mount Sinai models as a focus, this project will develop a conceptual approach to marketing social work service programs. Concepts and guidelines will be suggested to be employed by social work administrators concerned with the survival of existing programs or the creation of new ones. Principles of marketing and related theories on consumer utilization will be reviewed and those concepts selected that seem most relevant to the development of a market oriented approach suitable for social program planning and compatible with social work norms and values. Marketing theory together with studies on consumer utilization provide a broad theoretical and empirical perspective which should permit identification of factors affecting program acceptability, suitability and viability - all of which are crucial to program success and survival.

A. MARKETING THEORY

A Marketing Perspective Defined

The current economic trend in the United States and that of the foreseeable future is characterized by a marked decline in governmental funding for human service programs which has not been offset by philanthropic funds. Increasingly, professions such as social work need to think of themselves as marketable enterprizes which must compete for funds in a shrinking supply pool. This necessitates finding new ways to market themselves and their services; joining the open marketplace and competing effectively with other mental health professionals; and applying a business perspective to ensure continued fiscal solvency and proper management of programs.

In order to ensure both survival and enhancement of programs, marketing techniques employed in the business community with strategic planning seeking to define both consumer need and product demand appears to be essential not only for established social work programs but also for new ventures which seek to innovate programmatic models. Such strategy is primarily concerned with "designing and defining an organization's product or service in terms of the target market's needs, and on using effective pricing, communication and distribution to inform, motivate, and service the markets."[1]

According to Rosenberg and Weissman, "marketing is a special view of the business process designed to attract and keep customers... it emphasizes consumer needs as well as satisfaction."[2] The marketing philosophy is compatible with that of social work in the sense of being user, not seller, oriented and in its ultimate accountability to the consumer. This value principle has been enunciated by social administrators who advocate the primacy of the client in the helping process. Identification of the client and the client's interests and needs, the perception of the social climate of individuals and collections of individuals and the role of the social agency responding to human needs have been discussed by Slavin. He points out that "when a client perspective becomes the focal point of (agency) orientation then service needs set the conditions for creating an organization to meet them and should, as a normative principle, define the essential value orientation of those responsible for administering the service response."[3]

Demand and Supply: A Conceptual Framework for Viewing Marketing Tasks

There have been many articles assessing a marketing type approach among which most notably are the contributions of Philip Kotler. His framework for evaluating target market needs and product demand states highlights the various problems organizations encounter around regulating supply and demand.

Kotler develops a typology of eight strategic marketing problems that organizations most typically encounter.[4] The problems are formulated as "demand states": negative, nonexistent, latent, faltering, irregular, full, overfull and unwholesome. In each case the level of current demand is assessed in relation to the desired level of demand. Solutions for dealing with the various demand situations give rise to specific managerial tasks. The tasks combine administrative principles and marketing techniques.

> "All of these tasks require a managerial approach consisting of analysis, planning, implementation, organization and control. Furthermore, all utilize the two basic steps of marketing strategy development, defining the target markets and formulating a marketing mix out of the elements of product, price, promotion and place."[5]

In developing a theoretical perspective from which this program derives, particular attention was given to one of the demand states identified earlier - latent demand.

Latent Demand

> "A state of latent demand exists when a substantial number of people share a strong need for something which does not exist in the form of an actual product."[6]

Latent demand offers the marketer opportunities to develop new products and services that will meet a perceived need. Small cars with diesel fuel engines, light weight portable stereos, cable television, and low calorie foods are examples of latent demand products. The Arthur Lehman Counseling Service is an example of a social agency that identified a latent demand for social work services among middle and upper income groups. The agency developed a high quality counseling service, competed in the open marketplace with other disciplines rendering similar service, captured their target market, and became self funding on a fee-for-service basis. Similarly, the social work service projects at The Mount Sinai Medical Center are examples of a response to a latent market demand for service from middle and upper income patients seeking help with the social health needs and problems resulting from or related to illness and disability.

Converting latent demands into actual demands requires "developmental" marketing:[7]

- identifying the latent need and prospective product users
- developing the right product
- choosing the right price
- coordinating channels of distribution
- disseminating appropriate product information

Choosing a marketing strategy, even in cases where the demand seems assured, involves formulation of policy in four decision making areas: product, price, place (distribution), and promotion; typically referred to as the "marketing mix." Quelch offers a useful classification of these concepts from a managerial perspective:

> "Product policy defines the range of products, services or concepts to be marketed by the organization. Pricing is concerned with the costs in money and time that the consumer is willing to spend to obtain the product. Distribution (place) seeks to insure that the organization's products are efficiently delivered to the consumer at the appropriate time. Promotion must inform the consumer of the existence of the product - where, when and at what cost they can be obtained - and to persuade the consumer to take action to require them."[8]

Although they are treated as separate entities the components of the marketing mix are interrelated and must operate in a congruent fashion to ensure successful implementation. Changes in one element affect the others resulting in continuous monitoring, adjustments and modifications.

Products

Character of a Product

According to Kotler the character of a product can be distinguished by three concepts:[9]

> Tangible Product is the actual physical entity or organizational offering which is comprised of five characteristics. These traits would apply to a social service program as follows:
>
> - Quality level - degree of competency and expertise of provider
> - Feature - cost, availability
> - Styling - type and length of treatment offered
> - Brand name - formal name of service or program
> - Packaging - location where the service is offered
>
> Core Product is the benefit offered to the consumer.
>
> Augmented Product is all the benefits and costs incurred by the consumer in obtaining the products.

In addition, Kotler identifies dimensions of a product which, when combined with the above concepts, provide the full range of attributes that the consumer evaluates before he considers making the purchase. The dimensions are:

- Durability - will the effect of the product or service outlast the costs (money, time) invested to obtain it?
- Complexity - is the product too complicated to obtain or utilize?
- Familiarity - is the target population properly acquainted with the product or will it raise suspicions and be rejected?
- Visibility - is the product conspicuous and easily found?
- Risk - does the product represent too much personal or financial risk?

Introducing New Products

Once a product idea or service concept has been formulated and test marketed, a number of techniques can be applied which, according to Kotler and Zaltman, stimulate product adoption or utilization.[10] In the authors opinions these techniques are costly, have inherent risks, and do not represent a marketing mix that would normally be used to penetrate a market. However, these incentives are selectively utilized by corporations and small retailers to encourage rapid adoption of new products and may have applicability for non-profit organizations that wish to promote service programs in new client markets.

- charging a lower than planned price to stimulate earlier trial and repurchase of the product
- distributing free samples of the product to acquaint the market as rapidly as possible with the product's existence and virtues
- offering price-off coupons or premiums to stimulate earlier trial
- using higher-than-planned levels of advertising expenditures to increase the rate at which consumers learn about the new product

Such practices rarely occur in social agencies. Questions arise, however, as to whether this is because the use of incentives to promote new services is unethical or because this approach has not been custom in the social welfare community. In any case, their application would raise a number of policy issues in terms of who to include (potential clients or referral sources), what to offer, how much to offer, when to offer it and for how long.

Price

Social welfare programs that are not fully funded by external sources must establish pricing standards to recover operating costs and prevent deficit spending. In non-profit organizations income generated from funding sources and service utilization is calculated to identify the point at which costs equal revenues and the organization reaches break even. With public and private donor resources declining, many programs increasingly are going to have to look for ways of generating consumer income. Revenues from a paying clientele may thus be used for operating expenses as well as being a possible source of subsidy for less affluent clients.

Pricing strategies employed by the business sector have limited applicability to social programs in the sense that they seek to maximize profit. On the other hand, there are no set criteria for pricing services in the non-profit sector and, under present fiscal restraints, there is need to explore new ideas and approaches. Examples of strategies borrowed from the business community include: membership drives (churches, museums, etc.) where sales promotion prices are offered for a limited time to encourage demand (incentives); the current proposal that Medicaid patients pay a small fee for the purpose of discouraging misuse and overuse of the health system (disincentive). "Prices are not only an indicator of the rate of exchange but also communicators of a product's quality and consumer acceptability."[11] If potential consumers are willing and able to pay competitive prices for an innovative and desirable service, then a closer examination of the corporate approach to pricing may serve to inform our own practices or, at the very least, allow us to view them through a different lens.

Profit Maximization

Burck examined the myths and realities of corporate pricing. He takes the position that companies with innovative products which control the market should charge the maximum that people will pay. Many companies fail to do this for fear of being labeled "profiteers" and, in Burck's opinion, this is a mistake. Although his philosophy, which clearly supports profit maximization "charge whatever the traffic will bear," is contrary to social work norms and standards, he makes several points regarding pricing strategies which are worth noting.[12]

- A big backlog is an indication of an underpriced product.
- Always make decisions today that will help you tomorrow, and remember it's easier to cut prices tomorrow than raise them.
- The key to pricing is to build value into the product and price it accordingly.

Product Pricing Techniques

Strategic decisions for pricing products in new and developing markets fall into two major categories: "skimming pricing" and "penetration pricing".

<u>Skimming pricing</u> is a strategy which establishes a high price on an innovative product in the early stages of its marketing development. Dean cites four reasons why this approach has been successful in business:[13]

1. Sales of the product are likely to be less sensitive to price in the early stages when it has few close rivals then when the product matures and competitive imitations have appeared.
2. Launching a new product with a high price is an efficient device for breaking the market up into segments that differ in price elasticity of demand. Initial high prices serve to skim the "cream" of the market that is insensitive to price; subsequent price reductions tap successively more elastic sectors.

3. The initial high price can serve as a "refusal" price during the stage of exploration. Price reductions can follow but this is dependent on and related to product design and production efficiency.
4. High prices produce greater dollar volume sales which provide funds that can either be used to finance expansion into larger volume sectors of a given market, or be invested in other program areas where viability is threatened due to insufficient financial resources.

Penetration pricing is a strategy which uses low prices as an entering wedge to get into mass markets early. Dean notes a number of conditions under which this approach is most desirable:

1. When sales volume is very sensitive to price, even in the early stages of introduction.
2. When it is possible to achieve substantial economies in unit cost of manufacturing and distributing the product by operating at large volume.
3. When there is no "elite" market, i.e., no class of buyers willing to pay a higher price to obtain the newest and the best.

In sum, innovative programs designed for new target markets can provide additional funding opportunities for social agencies. Concepts borrowed from the business sector such as skimming and penetration pricing, though based on profit maximization, serve to inform decisions about when to use above, full or below cost pricing, how to determine what the market will accept, and where to re-invest surplus income.

Place

Place or distribution comprises all of the channels or outlets a product moves through until it finally reaches the consumer. In business terms it refers to the pathways and personnel involved in manufacturing, marketing, wholesaling and retailing a product, as well as the promotion and cost policies that guide these processes. For social programs, place or distribution is used in the broader sense to include geographical location, terms of product consumption and deployment of personnel.

In designing a new program or re-evaluating an existent one, consideration must be given to planning and selecting distribution channels in terms of how they will affect consumer product selection and acceptance. For example, selection of program location must take into account degree of accessibility, convenience, and proximity to public transportation. Other factors related to consumption are eligibility criteria, appointment policies, hours during which personnel are available, e.g., evenings and weekends if the consumer population is primarily composed of working people and families. Similarly, the deployment of personnel and whether home visits or outreach satellite programs are necessary are judgments which are made on the basis of the target population's needs. Finally, there is the issue of the type of facility, i.e., the physical plant that houses the programs where clients come into direct contact with the product or service. For example, the Arthur Lehman Counseling Service carefully selected and appropriately furnished a building on the upper East side of Manhattan's residential area which was attuned to the social class group they sought to attract. Kotler refers to the physical characteristics of an agency as "atmospherics;" their specific elements include:[14]

* Cognitions - exterior structures, interior space, displays, dress of personnel
* Olfactory - scent, freshness
* Tactile - softness, smoothness, temperature

Unfortunately, social agencies often fail to give adequate attention to the physical image they project because of their primary concern with functional issues. Consequently, clients may be subjected to unpleasant, depressing surroundings which impart an indifference to the feelings and sensitivities of the users and does little to either promote or maintain their continued patronage.

Promotion

A well designed promotional program can enhance the success of marketing a tangible product, idea or social program. Promotion is the communications element of the marketing mix. Holmes and Rieken define promotion "as the means by which organizations give information about themselves and try to persuade consumers to enter into exchange activities."[15]

Promotion is most commonly associated with the four principal modalities that stimulate product interest and desirability: advertising, public relations, sales promotion and personal selling. Advertising is a paid form of communication which requires considerable financial resources and long range planning. Public relations is a non-paid form of communication which entails development of news and promotional material and involvement of the media. Both of these approaches require significant amounts of time, effort and money and are most often utilized in large scale enterprises. In contrast, sales promotion and personal selling encompass a variety of activities which have utility for small program operations. Indeed, these activities, though referred to by different names, are often practiced by social workers in their day to day interfaces with client and donor constituencies.

Sales Promotion

Sales promotion consists of miscellaneous marketing activities that stimulate consumer purchasing and dealer effectiveness.[16] These low cost activities include: product displays and exhibitions, public service notices and outreach programs, consumer group marches and protest rallies.

Brochures and leaflets are additional forms of sales promotion which serve to inform consumers about the existence as well as content of programs. When such information is suitably tailored to the needs and preferences of the intended target group it is likely to capture their attention and promote interest in the program. Too often, social work programs lack specificity in describing their services and seek to appeal to broadly defined target populations rather than breaking them down into segments whose needs, resources and tastes vary significantly - if only slightly overall.

Personal Selling

Personal selling is a principal force in promoting industrial products. Increasingly, behavioral research studies are focusing on the roles and behaviors associated with effective selling styles and approaches as this function commands a sizable portion of marketing budgets and has a significant impact on product sales success.

In non-profit organizations, personal contact is a type of selling function which seeks to encourage client interest and participation. Because the critical point of contact between agency and client takes place through the agency representative or "sales person", these contacts are important determinants of program success or failure. In discussing marketing strategies for effective service or product promotion, Kotler emphasizes the importance of the contact function in relation to promoting consumer satisfaction:

> "(agency) personnel create distinct impressions upon clients in the way they dress, speak and treat people... the quality of their service has a direct influence on future patronage and satisfaction of the organization's customers."[17]

Some of the key issues to be considered concerning client-worker interactions are these:

Is similarity between the two parties, e.g., race, social class, sex, an important variable in determining a positive outcome (sale of product, consumer satisfaction)? Davis and Silk found that when three groups of salesmen and prospective clients were compared, the salesmen appeared to be more like the sold than unsold prospects.[18] Among the variables studied were demographics, backgrounds, physical characteristics and personality needs.

What types of behavior affect outcome; what part does interpersonal interaction play? For example, should social agencies control workers' attitudes, behaviors and operations with clients? How would this affect the notion of internalized professional norms and self directed practice; to what degree is control necessary and in whose interest - client or agency?

What policy considerations must be given to recruitment, selection and manpower planning; what procedures need to be implemented for rewarding and evaluating performance - if one accepts the premise that the rendering of service is a form of product sales, heavily influenced by interpersonal interactional processes, and the understanding and motivational participation of the worker in the purposes of the program.

Constraints and Concerns in Application of Marketing Theory

The foregoing discussion has explored the theoretical underpinnings of marketing theory and attempted to illustrate how the logic and strategies of these commercial concepts can be adapted for social program application. However, in order to maintain a balanced perspective, it is necessary to point out that there exists inherent constraints and limitations in applying these theories to human service programs and social causes. Authors who strongly support the use of marketing practices in the non-profit sector, raise concern about their potentially negative implications and consequences.

As Kotler and Zaltman note, "Because social marketing deals with core beliefs, and values, it must search harder for meaningful quid pro quos to gain acceptance of its products." [19] Rosenberg and Weissman in discussing the barriers to marketing social work services in health care settings, caution against allowing services to become an economic commodity, sold in the marketplace and distributed on the basis of who can afford to pay for them.[20]

At the extreme end of the continuum are authors like Kurt Reichert who seriously question whether the ideologies of private enterprize and social welfare can co-exist without endangering the mission and values of the social work profession.[21]

Reichert argues that, if social work adopts the market model as a structural base for its programs, it would drift away from its commitment to advancing social reform and serving disadvantaged classes. He views the creation of competitive, fee-for-service models and the emphasis on efficient productivity as undermining the notions of cooperation, comprehensive care, social justice, and reform.

The fundamental problem with Reichert's argument is that he tends to confuse market conditions, which are economic concepts, with marketing strategies, which are programmatic concepts. Thus he sees the marketing model as polarizing the choice between servicing potential 'markets-in-waiting' or population groups at risk. The development of entrepreneurial fee-for-service programs are viewed as being motivated more by profitability than social need. These developments are not, however, viewed in the context of problems and realities connected with the current fiscal restraints imposed on social work administrators and program planners.

What Reichert, it seems, fails to recognize is that the development of entrepreneurial program models which serve previously underattended client groups is not incompatible with social work norms and values. Indeed, the profession is obligated to provide service to all population groups where identifiable and unmet needs exist - regardless of economic or social status.

Reichert also tends to minimize the ways in which the market model can enhance social reform and justice by providing revenue for program continuation and maintenance. For example, revenues derived from a fee paying clientele can create a financial base for programs that serve disadvantaged populations and are suffering the effects of diminished governmental support. In fact, there is no evidence to support the contention that social work departments which have adopted the market model have abandoned their commitment to their underprivileged clients. In an era where there exists a surplus of social work manpower and a marked decline in available funding, it would seem that revenue producing programs which offer additional financial sources for underwriting worker salaries, creating job positions and maintaining day-to-day agency operations, are urgently needed.

From another perspective, application of marketing strategies to programs serving the economically disadvantaged and socially vulnerable can result in services which are highly responsive to consumer needs; thus enhancing professional accountability to groups that are dependent on social welfare programs but often lack the luxury of chosing and selecting their service facilities.

Regardless of whether one agrees with Reichert's point of view, his contributions merit attention and respect because they force us to struggle with the dilemma of maintaining a commitment to established professional norms, while finding innovative and creative solutions to deal with new sets of problems and issues.

As social work seeks to incorporate marketing principles into its practices, it must do so in the context of value considerations and with the knowledge of their potential benefits and limitations. The social work literature has only recently begun to examine how this can be accomplished.[22]

The potentially dysfunctional consequences - manipulative practices and the inherent power of the "persuasive arts" which can influence judgments and decisions; the costs of promoting social causes and programs which may surpass their net gain to specific groups or society as a whole - must be closely monitored and properly analyzed and documented to insure that both the pros and cons are objectively and fairly evaluated.

Given the present state of the art, one can only make broad generalizations regarding applicability of marketing strategies in relation to promoting worthwhile social objectives. Research, conducted on a case by case basis, will be needed before more detailed, normative generalizations and guidelines can be established.

B. CONSUMER UTILIZATION THEORY

Development of a marketing strategy for a product or service requires an understanding of the factors that affect its utilization. This includes knowledge about product design and development and about the nature of the market structure - who they are in terms of their lifestyles, needs and preferences; what their attitudes, motivations and behaviors are in relation to the product or its facsimile. Awareness of the social and environmental influences which bear on the decision making processes that guide product selection and consumption is an additional important factor.

Both the public health and medical sociology literatures have examined the subject of health care utilization extensively. By bringing together organizational, psychological, and sociocultural concepts they form a common theoretical framework which suggests that service utilization patterns are influenced by the psychological determinants, cultural norms and sociodemographic characteristics of the consumer population, and by the organizational structure of the health care delivery system.

In order to delimit the area of investigation, only those studies which have examined concepts of health service utilization in affluent or mixed socioeconomic patient populations are included for discussion. Within this grouping it is proposed to present two prototypical studies; each of which is representative of a major theoretical approach, and a third that employs a combined perspective with particular reference to middle class health care norms and behaviors.

An Organizational Perspective

The influence of the organizational structure on consumer health behaviors and utilization patterns can be seen in a study by Beloff and Korper.[23] The authors contend that most traditional medical practice settings provide "illness" care to their patients and that utilization patterns are determined by the patients' identification of symptomatic complaints. They identify the provider's philosophy of care as being a key determinant in influencing type and quantity of service utilized and in creating a demand for services offered. Evidence is presented to support the conclusion that service utilization patterns in traditional health care settings can be changed through modifications in the way services are delivered and organized.

In this study, 31 families were introduced to the concept of comprehensive care rendered by a multidisciplinary staff. They were offered psychosocial support services as well as biomedical treatment, the emphasis being on illness reduction and improved patient functioning. The authors hypothesized that the organizational structure and operational philosophy of this new type of service arrangement would ultimately alter the health behaviors and service utilization patterns of the study population.

Analysis of findings showed that, over time, physician contacts declined while contacts with non-medical personnel (nurse, social worker, nutritionist) rose significantly. Reductions in utilization of costly medical services and increased use of less expensive alternative support services suggested that patients had moved from an illness oriented behavior to one that was oriented to health maintenance and prevention. These shifting patterns were attributed to the influence of the organizational structure which offered preventive services and routine multidisciplinary involvement. In addition, the system actively supported and promoted a philosophy of health care which gave equal recognition to the social/emotional as well as the biomedical needs of its consumer population.

From a marketing perspective, it would seem that exposure to a multifaceted service system led to the identification and recognition of latent psychosocial health needs. This, in turn, generated a consumer demand for the innovative, non-traditional services, accompanied by a decreased use of physician time for non-medical health related problems.

Beloff and Korper's work underscores the importance of the operational philosophy of the health delivery system; its considerable influence on health consumer behaviors and service utilization patterns. It further implies that by varying situational circumstances, i.e., changing the nature and scope of services provided, one can alter patient health care attitudes and create a market demand for new and innovative types of service arrangements. Finally, they demonstrate that once traditionally treated patients gain access to and familiarity with a bio-psychosocial health care system approach, changes in utilization patterns should come to reflect a shift away from illness response patterns and toward a health maintenance and prevention orientation.

A Behavioral Perspective

Beloff and Korper were primarily concerned with the relative effects of organizational forces on utilization. As such, their model offers little explanation about the individual's role as a consumer of health care or about the attitudinal and motivational factors that influence individuals to select and utilize a particular source of care. In the health field, the most extensive work on attitude-behavior and utilization theory has targeted the individual consumer as a focal point of study. One example of this approach is Stratmann's model of attitude-behavior relationships which focuses on the final step in the utilization process - the selection of a source of care.[24] At this stage, the need for service has been recognized, there exists a willingness to invest time and money to obtain service; a decision must be made regarding the choice of a specific service source among those available.

A principal aim of Stratmann's study was to sort out and identify the universe of decision components that influence the consumer's choice to utilize a particular health care service or facility. A major contribution of Stratmann's work was the testing of his theory in an urban setting, involving the choice behavior of a representative sample of health consumers (N=521). The resultant sets of decision criteria provide a useful framework for explaining how consumers arrive at purchase and usage decisions and how these decisions are linked to subsequent utilization behaviors.

Stratmann contends that the market behavior which guides the choice of a health care service or facility results directly from the cognitive trade-offs perceived among five sets of decision components. The criteria categories are described as follows:

Economic factors - relate to the perceived utility of money: e.g., cost of service, payment schedule, loss of income incurred, availability of third-party insurance coverage.

Temporal factors - relate to perceived utility of time: e.g., waiting lists, efficiency of service, length of consultation, number of visits required.

Convenience factors - relate to the perception of utility of convenience: e.g., availability of service provider, home visits, special services, emergency or after-hour appointments, location of service, availability of transportation.

Sociopsychological factors - relate to the perception of utility of sociopsychological values: e.g., provider's manner, ethics, dependability, consumer/provider relationship, atmosphere of facility, privacy for patients, socioeconomic characteristics of other patients.

Care quality factors - relate to the perception of the utility of the quality of care: e.g., provider's familiarity with patients' problems, provider's professional competence and qualifications, range of services available, continuity of personnel, willingness to refer for specialized service.

The choice criteria are assessed from two standpoints - the extent to which the consumer believes the service possesses the desired attributes; the value the attribute has for the consumer, i.e., the extent to which it satisfies the requirement sought. Analysis of findings supported Stratmann's hypothesis that patients most often utilize the source of care that they calculate as having the greatest perceived value in terms of costs and benefits. In 80% of the cases studied, the choice calculated as having the greatest perceived value was predictive of the actual choice of facility most frequently utilized - a factor which suggests that health consumers do appear to act in rational conformity to their expectations.

The following series of propositions, derived from Stratmann's research and from analysis of buyer behavior theories and consumer decision-process models as described by Lunn in the marketing literature, provide a foundation on which to build a theory of consumer behavior.[25] These assumptions are based on a value principal that recognizes the consumer's prerogative to identify his own goals and needs:

1. Consumers are purposive and goal oriented. They can identify their perceived goals, and their actions and decisions with respect to health care utilization, are an attempt to satisfy their needs and motives.

2. The core of the decision process is a matching of products to the consumer's motives. Consumers seek information to satisfy various motives and structure information obtained from the environment as a guide to need satisfaction.

3. As a result of the combined forces of experience, education, cognitive ability and cultural influences, consumers establish categories of choice criteria which enable them to differentiate among the importance of these factors in relation to evaluating services and products.

4. Consumers can rank order their decision components and judge the expected satisfaction they may obtain from various product alternatives.

5. The selection of a source of care involves appraisals of costs and benefits. The choice to utilize a service is an explicit investment decision that involves evaluation of the relative importance of specific product attributes and estimate of the satisfaction to be accrued in relation to these attributes from alternative market sources.

6. Consumers will choose the alternative source of care associated with the highest present value of benefits in relation to costs. Utilization of a health related service is a function of the consumer's expected satisfaction with those aspects of the service process that matter to him.

Stratmann's model serves to illuminate some of the major factors influencing the choice process that guides service selection and utilization. It also establishes the importance of defining consumers in terms of their needs, values, beliefs and attitudes as they relate to a particular service or product field. Of particular significance, is the fact that health service utilization is viewed as a function of consumer satisfaction, thereby implying that the consumer's subjective appraisal of and reaction to a specific service system is an essential measure of its true merit and value. From this perspective it would seem that the success or failure of a health care service program is largely dependent on how well it provides for the welfare (needs) of its target population - as evidenced by their willingness to utilize the service; and on how well it satisfies the population for which it is intended - as evidenced by a positive reaction to the service experience.

Dual Perspective: Organizational/Behavioral

The previous models represent two distinct theoretical approaches which, when combined, broadly encompass some of the major factors that influence health service utilization. An integration of these dual perspectives is reflected in the work of medical sociologist Eliot Friedson who examined the utilization of social work services in a metropolitan health maintenance program.[26] The approach of this study was not to underscore the elements of success but rather those of failure and to analyze the reasons why this occurred.

In this project health services were delivered by a multidisciplinary team composed of a physician, public health nurse and social worker. One of its purposes was to introduce patients to the potential value of the more unfamiliar staff services. It was assumed that patients in a relatively prosperous area of the city had little exposure to social workers and public health nurses as part of their routine health care experiences.

Examination of service utilization patterns over a four year period, involving 144 patients, revealed that among the three disciplines, social work services were markedly underutilized by the patient population. Analysis of why this occurred led the researchers to conclude that service utilization is predominately affected by two factors:

1. The functional role of the service provider in the organizational structure
2. The sociocultural health orientations of the patient population

Friedson's study is an attempt to understand the nature of these two variables and their interrelationships.

Functional Role of the Service Provider

Friedson claims to have found a relationship between organizational role functions and service utilization. He offers several theoretical considerations regarding this point beginning with the premise that market response is more a function of the professional's role in the organizational structure than of the incumbent of that role. For example, Friedson's data demonstrated that underutilization of social work services in the health maintenance project could not be attributed to such factors as the training or personality of the worker but, rather, resulted from patients' perceptions of the function and position of the worker's role in the organization of services. Because patients conceived of social work as being non-medical in nature and functionally different and distinct from health care services commonly associated with routine health problems, they did not view it as relevant to their needs.

Friedson contends that organizational factors contributed to these misperceptions about the role and its potential utility for consumers. His data illustrates how the curtailment and limitations structurally imposed on social work resulted in its becoming a specialist function involved only with psychological, non-medical aspects of care and not with the everyday health related needs of the patient population. He further notes that when a role becomes "functionally specialized" it can lead to underutilization because its relevance to the central purpose of the organization becomes obscured.

From a structural perspective, "functional position" can be affected by organizational factors related to task allocation, role clarity and visibility. In Friedson's project, precluding the social worker from making home visits and failing to allocate to the worker those responsibilities and tasks customarily performed by this role in health care settings, created confusion and doubts in patients' minds and resulted in the disassociation of social work from the routine medical affairs and concrete environmental concerns of the consumer population. Because social work failed to achieve a legitimated, clearly defined status in the organizational structure, it had no logical basis for developing market appeal and, consequently, failed to attract the interest, acceptance and participation of the target client market.

Friedson's study demonstrates that accessibility and availability of service will not promote and sustain utilization unless additional factors such as task allocation, role clarity, visibility and practicality are considered in the short and long range planning process.

Specifically, this requires that:

- the service be structured in a manner that visibly links it to the organization's goals, missions and purposes

- the incumbent's role be integrated into the service delivery system in a fashion that retains its unique features and special expertise yet enables it to function as a complementary component part of the total organization

- the tasks and responsibilities of the role reflect the needs, concerns and demands of the target consumer population and be made known to them in concrete and familiar terms

Sociocultural Norms and Health Care Service Utilization

Friedson's comprehensive perspective on utilization not only addresses organizational structures but also looks at the sociocultural factors that influence this phenomenon. Because his analysis focuses on diverse socioeconomic patient groups, it offers valuable observations about differential use of health related services and about how cultural norms dictate the process of seeking and utilizing professional help. Of particular interest to this project is his examination of middle class health orientations and their effect on consumer motivation and social work service utilization. Friedson's single most important assumption is that patient cultures contain norms about the problems patients perceive and about the process of seeking help for those problems. The consumer's decision to utilize a particular professional service is based on his knowledge and acceptance of that professional as being the one best qualified to deal with his need or concern. Friedson shows, however, that knowledge and acceptance of professional roles and functions tend to vary among patient groups; utilization choices and responses reflect class differences.

In analyzing social work utilization patterns he found that although resistance to social work was a general characteristic of the study population as a whole, upper middle class patients were more positively oriented toward the social worker than lower class patients; the proportion of upper middle class patients choosing to retain the services of the social worker was greater than that of the lower class.

Differences in response between the two groups were attributed to the following factors:

- Upper middle class patients tended to define their problems in psychological as well as physical terms, were knowledgeable about the role of the modern social worker, and had a clear perception of the need for counseling in a health care practice setting.
- Lower class patients, on the other hand, were not prone to perceive problems in psychological terms, tended to define them as being caused by physical and environmental factors, and viewed behavior as a fundamentally immutable characteristic which was not amenable to change through counseling or insight.

Overall, reactions to social work were thought to be affected by its functionally specialized status which served to isolate it from the more familiar health care services provided. As a specialist, the social worker appeared to be disengaged from the patients prevailing conceptions about the nature of the problems needing professional help and viewed as a resource for serious, extraordinary situations which were not amenable to routine treatment. Although upper middle class consumers tended to look upon the service more favorably than those of the lower class, neither group was at a stage in the care seeking process where the need for a "specialist" involved exclusively with psychological concerns was significant. Friedson hypothesizes that had the role been structured to include more concrete and generalized types of functions; had it been more attuned to patients' norms about their health care requirements, it might have been more appealing and acceptable to the target consumer population.

In essence, it is suggested that patients have culturally bound norms about illness and health which order the process of seeking care. Furthermore, utilization of a particular service may depend on whether a proper "fit" is achieved between the consumer market's knowledge and perception of the professional's role; their needs at a given point of the care seeking process, and the way the service is organized. To quote Friedson, "choice and utilization of professional services may be understood as a function of the relation of the content and organization of professional services to the content and organization of the process by which patients seek help."[27]

The core of the decision process is thus seen as a matching of service to consumer motives and perceptions about professional roles. Sociocultural influences have a distinct function in informing consumer awareness, choice criteria, attitudes and utilization intentions. Friedsons's critical point is that there exists an interdependence between sociocultural and organizational variables; both constitute major influences on consumer motivation and utilization behaviors.

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The theoretical formulations and variables discussed in this chapter will be reflected in the design of instruments to evaluate consumer preferences and perceptions of institutionally based, private social work service health care delivery models, and serve as a framework for the development of a marketing strategy.

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CHAPTER IV. METHODOLOGY: PROJECT DESIGN AND IMPLEMENTATION

Timeliness/Appropriateness

There were a number of congruent indications for implementing the study at this time. The first related to increased survivorship among middle class sufferers of chronic illness; the resulting escalation of health care costs, and the need for psychosocial supports among these patient groups. The second dealt with the fact that declining resources for social work service programs has affected institutional delivery of such services for all population classes by reducing funding for salary lines and program development. The third dealt with the relationship of disease-specific social services to current Diagnostic Related Groups (DRG) reimbursement and the possible indications for future support of in-patient and ambulatory DRG related reimbursement for social work services.

All of these points are potentially well served by developing fee-for-service programs tailored to the needs and preferences of the private health consumer market. Success of such approaches offers a means of achieving health care economies through the provision of psychosocial supports and has important implications for expanding third party insurance coverage for social work services. Engagement of a fee-for-service clientele will also allow for better maintenance of current social work health care programs as the trend increases in the voluntary sector to raise more money from operations in response to fiscal cutbacks.

The application of marketing theory to promote and enhance client acceptance and utilization of service programs, therefore, seems indeed timely. This theory permits a more direct appreciation of the factors inherent in client acceptance and their relationship to program success and survival.

The Mount Sinai Medical Center has been most interested in the application of marketing based evaluation techniques in the assessment of existing fee-for-service models. In line with this, full support was offered for this project.

Feasibility

Funding

The project was implemented through the normal support channels provided by the Division of Social Work Services, Mount Sinai Medical Center. It did not incur any significant monetary costs with respect to materials or manpower. The student assumed full responsibility for its development, implementation and evaluation.

Operational Issues

There were no major obstacles or constraints to hinder implementation of this project. The collaborating private physician and Myasthenia Gravis social worker offered full cooperation in developing the project and judged it to be of significant importance to myasthenia gravis patients.

Project Goals

The ultimate goals for this project were:

1. To make the concepts of commercial marketing accessible, relevant and acceptable for social work program developers by translating their logic and strategies into social welfare analogies.

2. To demonstrate how marketing theory can assist social work programs in health care to be more responsive to consumer needs

and preferences.3.To suggest strategies and guidelines for promoting social work health care programs to be employed by administrators, educators and practitioners who are engaged in the development of new program models and the evaluation of established service projects.

Intermediate Objectives (Purpose of the Project)

The above stated goals were reflected in the objectives of the study project. These objectives were:

1. To develop a strategy for marketing hospital-based social work programs for chronically ill patients treated in the private medical sector.
2. To provide a framework for identifying consumers' different needs and preferences and assessing factors affecting acceptance and utilization of private, fee-for-service social work health care programs.
3. To demonstrate how consumer survey data can be applied to the design and development of social work service health care programs in order to enhance their responsiveness, appeal and marketability.

Long Term Objective

To explore the potential for further development and expansion of hospital-based social work service health care delivery models for chronically ill patients treated in the private medical sector by contributing to the profession's knowledge and understanding of this new programmatic area, and by providing an approach for marketing the programs to potential client groups.

Operational Objectives (Project Products and Results)

The proposed project sought to achieve its objectives by:

1. Providing a descriptive analysis of the range of private, fee-for-service social work health care programs currently operating in a tertiary, metropolitan medical center.

2. Developing an instrument, based on marketing principles and health consumer utilization theories, to evaluate consumer needs, preferences and perceptions of a hospital-based private social work service program.
3. Implementing a consumer analysis survey which consisted of administering a mailed questionnaire to a disease-specific, chronically ill population. The study sample was drawn from a private medical practice setting that had established a social work service program under hospital-based auspices.

4. Formulating projections and recommendations for program marketing, i.e., product modification, development and promotion, based on an analysis of consumers' subjective ratings.

Auspices

Over the past months, support and interest for the concept of this project had been evidenced by doctoral committee members at the Hunter College School of Social Work. The written proposal was submitted for their formal approval and endorsement during the winter of 1985. In the spring of 1985, the project was carried out under the aegis of the Murray M. Rosenberg Applied Social Work Research Center of the Division of Social Work, Department of Community Medicine, Mount Sinai School of Medicine.

The Hunter College School of Social Work doctoral faculty and select members of the Advisory Committee of the Murray M. Rosenberg Applied Social Work Research Center acted as consultants for refining project ideas and as a basis of support to ensure smooth operation of the project during its implementation. In addition, consultations were held with faculty members of Baruch College who had special expertise in the field of marketing.

Project Setting

The Mount Sinai Medical Center is a 1,200-bed, voluntary acute care tertiary and primary university medical center located on the border of East Harlem and the upper east side of Manhattan. The Department of Social Work Services has traditionally provided counseling and support services for the institution's disadvantaged and indigent patient populations. In recent years, these services have been extended to groups of private patients under several different types of organizational arrangements.

The formal inclusion of private patients as service recipients dates back to 1966 when the Board of Trustees officially recognized the need to extend social work services to these patient groups.[1] Prior to that time, private service coverage did not exist on a structured basis. Private patient referrals were taken on request from physicians or from the private pavilions. Provision of service to private patients was given additional impetus in 1975 as a result of the development of policy guidelines for utilization review and discharge planning that required social workers to screen cases on the basis of high social risk criteria. This was undertaken in response to New York State cost containment regulations (1975) stipulating measures for monitoring patient admissions, discharges; and quality of care rendered.

A high social risk screening mechanism was developed for the purpose of identifying patients at risk.[2,3] In applying high social risk principles to social work assessment and treatment, the Department affirmed its commitment to provide service to all socioeconomic groups, regardless of economic status. As Paneth and Lipsky point out, "while patients in the lower socioeconomic level were regarded as having possible vulnerability, high social risk was not limited to that group."[4] Among the illness categories designated for high risk screening were the major chronic illness groups.

This project has examined the private social work service programs currently operating under the Medical Center's auspices. These fee-for-service models have begun, to varying degrees, to involve chronically ill, middle and upper class patient populations treated in the private medical sector.

The focus of the research project was the Myasthenia Gravis model. It was chosen as a prototype for private social work practice marketing efforts because it is believed to have applicability to other chronic disorders and significance as a model for chronically ill populations in general. Its suitability for prototypical model development and hypothesis testing relates to factors concerning the nature of the psychosocial problems and treatment requirements of the populations served.

This model was in line with the primary concentration and objectives of the dissertation project which were to examine chronically ill populations, their problems and requirements relevant to illness; and to develop a strategy for marketing hospital-based social work service programs for patient groups treated in private medical settings. These objectives were premised on the assumption that chronically ill patients suffer from a multiplicity of psychosocial and social/environmental problems and can benefit from social work support and counseling services. Based on this assumption, physicians who treat these populations will need to make social work services available to their patients and know how to maximize its acceptability and promote participation.

From the point of view of feasibility and practicality, the model was chosen for project implementation for reasons related to its programmatic structure, the nature of the patient population and their accessibility, and the professional staff's evidenced cooperation and interest in this project.

The Myasthenia Gravis model structurally operates under hospital-based auspices and was designed for the purpose of making disease-specific social work services available to chronically ill patients treated in a private medical setting. This fee-for-service model has a definable market of existent and potential service users and affords the opportunity to promote the service on the basis of programmatic, rather than individual (worker) personality factors because numerous workers have been associated with it, over time.

In addition, the private physician and the private social worker have indicated full support for the project and a desire to expand the existing program's marketing potential. In line with this, they granted access to patients and agreed to make all necessary records available.

Because of these combined factors, the model was thought to be highly suitable, both theoretically and practically, for the type of marketing analysis approach undertaken in this project.

Methodology

I. Survey of Models and Selection of a Study Setting

In the initial phase of the study, the range of private, fee-for-service social work models operating in the Medical Center were identified and explored.

A questionnaire was designed which served as a basis for interviewing administrators, line social work staff and medical personnel who were knowledgeable about this programmatic area (see Appendix A).

The questionnaire examined the models with respect to their historical backgrounds and development, consumer populations served, administrative and financial structures and support systems, and current programmatic and marketing activities. Because it was very broad in its scope, not all of the issues raised were relevant for each model.

The questionnaire had greatest applicability to models that were predominantly concerned with engaging private, fee paying health service consumers; had developed comprehensive service programs for these patient groups with explicit medical center linkages; and were interested in expanding marketing activities to increase consumer participation. It provided a contextual framework for assessing the inherent study possibilities and limitations of each approach, which was a prerequisite to selecting a suitable setting for implementation of the research project.

As previously mentioned, the Myasthenia Gravis model was chosen because its finite nature, organizational structure and accessibility made it a most suitable and feasible choice for conducting an evaluation of the factors under study.

The initial phase of the study was completed in November 1984. Numerous interviews involving eleven people were conducted. On the basis of the data derived from the survey, a descriptive analysis of the models, highlighting their unique features and structural variations, will be presented in Chapter V. Material of a sensitive or confidential nature that concerns the institution, staff or patients will be omitted from that discussion.

II. Instrument Development

A central task of this project was to develop a beginning survey instrument to measure consumers' attitudes toward and perceptions of private social work health care service programs (See Appendix B). The aim was to determine which of the program's attributes the consumer views as most important, in order to market the service effectively. Conceptually, the parameters of the questionnaire reflected the four dimensions of a service program: product, price, place and promotion. The strategy for developing this instrument was to combine marketing principles and research techniques with social work consumer survey methodologies.

With this strategy in mind, questionnaire items relating to elements of social service provision (product elements) were based on the classification system used in the Berkman-Rehr Classification of Psychosocial Problems and Outcomes.[5] This instrument categorizes the requests patients with illness make of social workers and the outcomes of services provided in relation to these requests. It has had widespread use in hospital settings throughout the country as a means for evaluating psychosocial problems and outcomes. Extensive use of the classification system supported the fact that it had face and content validity for hospital-based social work service programs. Product elements were tailored, in some instances, to reflect the special needs and requirements of the myasthenic population. This served to enhance the instrument's relevancy. The private physician and myasthenic social worker played an instrumental role in shaping these items. Additional items related to program dimensions of price, place and promotion were based on the conceptual definitions identified in marketing theory (See Chapter III).

All items were arranged into a self-administered questionnaire and pretested with a subsample group of four myasthenic private patients, to determine clarity and specificity, time of completion and additional information that could be relevant to the study. It was also reviewed by social work and medical professionals who had experience with the private social work program models. Both providers and consumers gave valuable feedback about whether the items were reflective of the program's attributes and were consistent with the concept being measured. These procedures helped to establish the validity of the instrument. The minor suggestions that were offered dealt mainly with the service components in Part A, and were incorporated in the final version.

Respondents were asked to rate the importance of prespecified service program components (Part A) and features (Part B), in accordance with their needs and preferences, using an ordinal scale. The rating technique is frequently used by market researchers to measure consumer attitudes about the relative importance of various attributes of a product.[6,7] An advantage of this approach is that the task is not difficult to understand or time consuming to complete.

In keeping with the format of a consumer analysis survey, questions were also included which determined consumer familiarity with the product, utilization intention, interest in receiving additional product information, and prior product (counseling) experience. The purpose of these questions was to measure levels of consumer awareness of the product and potential interest in using it.

In addition, there was a section on sociodemographic information and one that pertained to patients who had previous, direct experience with the model under study. The section for prior and current myasthenia social work users sought to determine points of entry into the program, factors influencing choice and levels of satisfaction.

The format of the instrument contained a combination of both closed and open-ended items. The purpose was to allow for greater exploration of issues which pertained to the market as a whole or to various select segments.

III. Sample Selection

Myasthenic patients treated by the Chief of the Myasthenia Gravis Clinic and Research Laboratory of the Mount Sinai Medical Center were chosen as the target study population. Within this physician's practice, there exists a large cohort of private patients. Because of his interest in promoting social work services for his patients, he agreed to make his private patient rosters available for the entire year of 1984.

A non-randomized study sample was selected consisting of all private patients with a diagnosis of Myasthenia Gravis who have been treated by the collaborating physician during the one year time period (total number = 121). For purposes of this study, private patients are defined as those who were treated by private physicians and are considered to be fee eligible according to the guidelines and fee charging policies established by the Division of Social Work Services (See Appendix C). In these patient groups, fee expenses are customarily met by direct payment and/or private third party insurance coverage.

Data on the population was gathered according to medical and sociodemographic variables. The classifications consisted of general, descriptive characteristics; specific, illness-related factors; and social work service utilization information. Patients' medical records were the primary source of this data.

A. General Background Variables included commonly identified sociodemographic characteristics:

- Age, sex, race, ethnicity
- Education
- Occupation
- Marital status
- Family size

B. Illness Related Variables included:

- Severity of illness: the medical staging of the illness as measured by the Osserman Clinical Classification of Myasthenia Gravis. This procedure was physician and chart annotated.

  The Classification System is as follows:

Stage I	Purely ocular
Stage IA	Ocular symptoms only with electrophysiological evidence of generalization
Stage IIA	Mild generalized myasthenia, predominantly skeletal (arms and legs)
Stage IIB	Mild generalized myasthenia with, however, bulbar symptoms (dysphagia; dysarthria and respiratory difficulty)
Stage III	Acute fulminant myasthenia with progression from mild ocular symptoms to severe disability within six months
Stage IV	Late severe generalized myasthenia gravis
Remission Stage	Relief of all myasthenic symptoms, no response to anticholinesterase medication, though there may be residual fixed deficits

- Length of time since diagnosis - It was hypothesized that this category might show differences in service preferences between recently diagnosed patients and those who have adapted to the illness over time.
- History of hospitalization, though part of the original plan, was eliminated as a study variable because it was too difficult and complex to measure. Myasthenic patients are often hospitalized during the course of their illness for routine and necessary treatment procedures and are entitled to in-patient social work services at no "apparent cost, as part of the third party reimbursement formula.

C. Social Work Service Users/Non-users

This category identified patients who have or have not participated in the Myasthenia Gravis, private social work service program.

Confidentiality:

The following steps was taken to insure confidentiality of respondents:

1. All patient information was coded so that names do not appear.
2. Patient name-code lists were exclusively under the control of the student, with access available only to authorized project staff.
3. If individual information was used for illustrative purposes, any identifying information was disguised.
4. All name-code lists and original response data were destroyed at the conclusion of the project.
5. Patients were informed in the letter that accompanied the questionnaire that their confidentiality would be protected, and that refusal to participate in the study would not jeopardize their relationship with the physician in any way.

IV. Data Collection

The primary sources for data collection in this study were patients' office medical records for background information, and self-administered, mailed questionnaires. A covering letter, accompanying the questionnaire, was signed by the collaborating physician (Appendix D). The letter provided information on the social work service program; explained the purpose of the study, and how the information was to be used. It also assured patients that their responses were confidential.

When the questionnaires were mailed to the 121 patients, they contained a typing error which affected the rating scale in Part A. Scale item #4 which read as "very important" should have read as "very unimportant". A notice went out to all patients within the same 24 hour period, advising them of the error (See Appendix E).

When the questionnaires were returned, over 90% of the respondents indicated awarness of the error by noting the correction on the instrument. In cases where there were no such indications, the items rated with the incorrect scale numbers were omitted from the final tabulation.

Five weeks after the original mailing (official cutoff date for the study), 100 questionnaires were returned. This exceedingly high response rate (82%) might be due, in part, to the fact that the physician had agreed to sign the covering letter that accompanied the questionniare. The factor of physician endorsement could be a significant determinant in motivating patients to respond. In addition, the fact that diseases like Myasthenia Gravis are not as well known as the highly publicized major chronic illnesses such as cancer or coronary heart disease, may be significant. Patients with these lesser known illnesses tend to become involved in their own public relations work and must rely on relatively few resouces to fund and produce research, or take an active interest in their cause. Consequently, there is often an eagerness to assist those who are attempting to help them. Thus, for the reasons stated, it is assumed that these combined factors may have been the primary motivating forces in promoting cooperation and a willingness to share information.

V. Statistical Methods

The completed questionnaires were coded and subjected to a series of statistical analyses. All categorical data was analyzed by means of frequency distributions. Statistically significant differences were determined by means of chi-square analysis.

Service components and features were examined by means of factor analysis. Multiple regression analyses were used to determine if there were any significant differences in program variables, controlling for sociodemographic characteristics.

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CHAPTER V. DATA ANALYSIS AND EVALUATION OF FINDINGS

This chapter will report the findings and results of the private social work model survey and the consumer marketing analysis survey. The implications of these findings will be the subject of Chapter VI.

A. PRIVATE FEE-FOR-SERVICE SOCIAL WORK MODELS

Classification System

The survey conducted in Fall 1984, resulted in identification of seven fee-for-service models operating in the Medical Center. The models are as follows:

1. The Medical Service Plan Model
2. The Learning Disabilities Clinic Model
3. The Perinatology Model
4. The Internal Medical Associates Model (IMA)
5. The Social Work Service Plan Model
6. The Geriatric Model
7. The Myasthenia Gravis Model

In the process of analyzing the distinctive features of the models, a classification system was devised which categorized the various practice arrangements according to certain criteria. These criteria were based on factors relating to the program's defined parameters, focus and type of patient population served.

For example, Classification I would include <u>disease or diagnostic-specific patient groups</u>. The Myasthenia Gravis, Learning Disabilities Clinic, and Perinatology models would be included in this category.

Other examples of types of specialized medical practices that might be included in this classification are: cancer, arthritis and lupus.

Classification II would include population-specific groupings such as the Geriatric and IMA models. Other examples of Classification II practices are: pediatrics, family medicine, internal medicine and obstetrics/gynecology.

The criterion for Classification III is based on the structure of the social work practice arrangement and would be applicable to practice-specific models such as the social work service plan and medical service plan.

Thus Classification III would relate to specific social work practice arrangements that have training value and/or provide incentives for the department's staff and faculty members.

In arriving at this typology for analyzing medical practice arrangements, the classification system applied Barnard's concepts of homogeneity (patients who are medically similar) and specificity (patients who are medically distinct from other patients) to the task of defining service program "product lines", e.g., for Classifications I and II.[1]

Thus, in Classification I the criterion of specificity would be applied toward identifying those patient groups who are medically distinct and unique in a diagnostic sense and, who require specialized therapeutic treatment services. In Classification II the criterion of distinguishing homogeneity can be applied to broadly defined patient groups who are medically similar and generally undifferentiated in medical management terms. In Classification III, the relevant factor is the nature and structure of the practice arrangement itself; and not the target population served.

It is believed, that this classification system will be useful to social work health care administrators because it permits evaluation of programmatic potential of medical practices and services within institutional settings as well as externally in the community, on the basis of their structural features. Such analysis is necessary for strategic planning and operational decision making.

Because medical services often overlap and have multiple foci, the categories presented should not be treated as rigidly defined entities. Rather this system should serve as a flexible framework for analyzing the target consumer markets, service requirements and revenue producing possibilities of medical practice settings which have potential for fee-for-service, private social work program development.

Descriptive Analysis

The questionnaire on fee-for-service models served as a basis for conducting structured interviews with Medical Center personnel who were involved with the models either operationally or administratively. Although seven models were identified as serving private patients and charging fees, the degree to which they engaged a private, fee paying clientele, varied greatly; as did their fee charging policies.

As noted earlier, the questionnaire had greatest applicability to models that were actively seeking to engage private medical patients, had developed services for these patients which were explicitly linked to the Medical Center, had established a fee system based on the notion of open market competition; and were interested in expanding marketing activity to increase consumer participation.

As the subsequent analysis will show, the three models that best met these criteria; hence proved to have the most extensive marketing possibilities, were the Myasthenia Gravis, Geriatric, and Social Work Service Plan models. Accordingly, they will be analyzed in greatest depth, following descriptions of the other model types.

1. <u>Medical Service Plan Model:</u>

The Medical Service Plan model enables social work professionals with faculty appointments to supplement their income within predetermined contractual guidelines, by maintaining a private practice in addition to their service responsibilities. Participation in the plan is mandatory for all full-time faculty members in the Medical Center who are involved in private practice activities. At the time of this writing six social work faculty members were participating in the plan.

Overhead costs, to cover office space, telephone, clerical services and supplies, are calculated at 10% of income. An additional 10% allocation is split between the Social Work Service Departmental Fund and the Department of Community Medicine Fund.

The patient populations served are diverse in nature, the problems are not predominantly medically related; referrals can come from community, professional and institutional sources, or from patients themselves.

Guidelines for the Medical Service Plan are established by the Medical Center. The model has not evolved out of social work practice principles but, rather, has been developed as a result of institutional policy. The chief advantage of this model is that it can reduce budgetary needs for departments within the institution; and at the same time enable staff to earn appropriate competitive wages. The difficulty in such a model is to maintain a professional balance between the individual's departmental activities and the need to earn supplemental income. If such proportionality is not constantly re-evaluated, it may result in the need to hire additional personnel in order to adequately discharge departmental responsibilities.

2. Learning Disability Clinic Model:

The Learning Disability Clinic offers comprehensive services to learning disabled children and their families.

All patients are required to participate in an initial evaluation process upon entry into the program. The social work assessment is one component of this procedure which is composed of multidisciplinary services.

There is a fee for the social work portion of the evaluation, and fee eligible patients are charged on a sliding scale. Fees are usually covered by private third party insurance as part of the total evaluation package. Charges and billing procedures are handled by the clinic staff; all revenues generated from social work services are allocated to the Ambulatory Care Department Fund.

In this model, the social work function is considered to be an integral part of the overall care and treatment services rendered by the clinic team. Beyond the one time payment for evaluation, there are no independent charges for social work services for fee eligible patients. Thus, the charges for social work are limited to a specific type of service which is mandatory for all patients as part of a comprehensive treatment protocol.

At present, there are no programmatic efforts to specifically engage a fee paying clientele and establish additional on-going charges for social work services as an independent treatment modality functioning within a specialized setting.

3. Perinatology Model:

The Division of Perinatology has a full-time social worker who provides service for clinic and private high risk maternity patients. Up until recently the social work position was half-time; primarily involved with the clinic patient population. When the perinatologists decided to make social work available to their private patients, they agreed to fund an additional half-time social work position.

In this model, private patients are not charged directly for social work services. Rather, the cost of service is administratively absorbed and passed along indirectly to the consumer in the form of treatment and other fee charges. Thus, the expense of delivering social work services is spread out over the total patient population; there are no individual, direct variable charges for service utilization.

The rationale for employing this funding strategy is based on the notion that, because the perinatal population is at risk for medical and psychosocial crises, they should have access to social work counseling and support services. There is concern, however, that because these patients are unfamiliar with the social worker's role and function in the private medical setting, they would not utilize the service as readily if there was an explicit fee charge. Thus, charging consumers a fee-for-service is viewed as a potentially limiting factor with respect to the level of utilization and income production needed to cover salary expenses. By costing social work service into the overall rate for medical care, these risks would appear to be minimized.

This model is illustrative of a strategy which targeted marketing efforts at medical providers who valued the service for their private patients. There is, however, an implicit notion that the patients themselves would not utilize the service if they were directly asked to pay for it.

4. Internal Medical Associates Model (IMA):

The following description of the primary care group practice model is based on an article written by Sylvia Clarke and Linda Neuwirth.[2] Staff interviews and project reports provided supplemental data.

The impetus for this model arose from administrative concern about the institution's general medical clinics with their problems of disjointed, discontinuous care, which was inadequate for patients, unrewarding for physicians, and costly to the institution. An interdisciplinary group was charged to design a viable alternate structure to the clinic. The process was accelerated by a five year grant of one million dollars from the R. W. Johnson Foundation for a demonstration model which started in 1980.

By employing a bio-psycho-social frame of reference, the model provides patients with a planned way of identification and treatment of those psychosocial problems which interlock with their medical problems and contributes to achieving the groups practice goals of coordinated, comprehensive, unfragmented, and economic care. The social worker is cast both as the primary health care provider for the treatment of patients' psychosocial problems, and the primary health practitioner for the practice.

This medical group fee-for-service practice structure was built on primary care tenets. The original intent was to establish a one class system of care for both clinic and private patients and provide the same treatment opportunities regardless of socio-economic status. Thus, social work would generate income through payments for visits by third party private and public insurance plans and through charges for "self-pay" patients. This income would offset the major salary costs of social work staff.

In fact, the original goal of attracting a mixed patient population was never achieved. It was anticipated that the patient population would consist of one third Medicaid/Medicare patients, one third self-pay (middle income) patients, and one third working poor patients.

The current population served by the model is almost totally comprised of Medicaid and Medicare patients. The revenue production figures for social work services for the first eight months of 1984 were: 0.03% self-pay and 97.0% Medicaid.

In the course of interviewing IMA social work staff, a number of issues came to light concerning why the model failed to engage a self-pay, middle income, private patient group. Among the factors cited as discouraging middle class patient participation were:

1) The model cannot offer the same type of continuity and individualized care as would a private, independent medical practice. Because IMA is a component of the Medical Center, it is obligated to serve an underprivileged population in the hospital's cachement area and function as an outpatient training system for 83 rotating medical house staff. The attending physicians in the group primarily act as preceptors with only a small private practice caseload of their own.

2) The environment of the setting is not conducive to the tastes and expectations of patients treated in the private sector. Although the physical setting was intended to resemble a private medical office, the facility lacks the resources to adequately accommodate the number of patients it serves. Consequently, the waiting room is overcrowded and noisy and the phones are consistently busy. Such conditions make it difficult to contact the service and unpleasant to wait for an appointment.

3) The appointment hours are inconvenient for working, middle class patients. The fact that the practice has no evening hour appointments available, especially for the mental health service component, is a problem for patients who cannot disrupt their work schedules on a

routine basis and require appointments after working hours.

With respect to the structural design of this model, all income generated by social work is allocated to the IMA Fund. Social work fees for self-pay patients are based on the Ambulatory Care rate scale and are calculated at half of the rate charged for a medical clinic visit. This enables patients to engage in on-going service at an affordable price.

The social workers' salaries are paid by the IMA practice; their accountability is to the Department of Social Work Services. While Social workers are viewed as equal partners with physicians with respect to providing care, they do not share in any profits generated from the practice - as do the physician partners. On the other hand, because the social workers' salaries are not tied to revenue production, they are not at risk for loss of income.

5. Social Work Service Plan Model:

Approximately five years ago the Department of Social Work Services created a fee charging program for private consumers who were receiving social work services that were not considered to be "mandatory", i.e., rendered in conjunction with the medical care provided by the institution.

The rationale for instituting charges where none had existed before grew out of a belief that certain groups of patients would use and pay for services if they were made available to them, and that social work service had sufficient value and appeal to compete with other mental health professions in the market place. Additional factors influencing the creation of this program related to concerns over diminishing resources for human service programs; the need to establish self-funding mechanisms to maintain departmental operations.

The guidelines developed in 1980 specified which patients could be charged fees and set preliminary standards for eligibility (See Appendix C). The two main groups who were eligible to participate on a fee-for-service basis were:

1) Patients/families who were never registered in the Mount Sinai system and would normally fall into the "courtesy" category:
    - private patients receiving medical care from a private attending physician
    - friends and relatives of patients previously known to the medical center
2) Patients/families requesting services after their mandated services have been completed:
    - post hospitalization contacts of patients/families whose post hospital medical care is done privately or by another institution
    - ambulatory patients of private physicians

The aim of this program was to capture the consumer market treated in the private sector that was previously receiving social work services at no cost. To what degree their needs are related to illness has not, as yet, been determined nor has the exact nature of the patient population been defined.

The program operates on a center-wide basis. Any individual judged to be eligible can receive service; this includes those connected to or outside of the medical center network. Social workers do their own case finding or receive referrals from other sources. Any worker can participate in the program, although the senior clinical workers take the majority of cases referred by private physicians.

Fees are charged on a sliding scale. All income generated by fees is retained by the Department of Social Work Services. Patients are seen in the social worker's office which may be located in any part of the institution. There are no special overhead or supplemental charges incurred by the program; billing and fee collecting procedures are carried out through established departmental systems.

Design and Operational Issues

When the model was initially implemented, a series of staff training seminars were conducted which addressed the multitude of practical and ethical issues connected with serving a fee paying social work clientele in a non-profit medical center setting. These seminars served an educative as well as promotional function because they encouraged worker participation in a new type of practice arrangement, and taught them how to attract, engage and serve a private clientele.

Over time, the seminars were phased out as departmental priorities shifted and new programmatic directions emerged. Today, the model operates in a rather loosely structured fashion due to the pressing and overwhelming demands on manpower and time created by the clinic populations served by the Medical Center. These service demands limit the availability of administrative and supervisory manpower required for encouraging worker participation and maintaining and monitoring operational functions. They also result in workers having little time in the course of the routine work day to engage and treat other patient population groups.

Nonetheless, despite these factors, the model is functionally operational insofar as a number of staff do participate and carry ongoing private caseloads, in addition to their primary responsibilities.

In examining the model as it operates today, several structural problems were uncovered which serve to highlight the types of supports needed to maximize its operational potential. One can see how the absence of certain types of formal administrative support mechanisms affect programmatic and financial accountability factors as well as worker productivity. For example, worker participation is not mandatory but is, rather, dependent on individual initiative. In addition, there are no established case quotas or specific incentives for engaging fee paying clients. The primary incentives consist of workers experiencing a varied caseload mix and having an opportunity to generate funds for the department. Stronger incentives and standards might result in greater participation and more aggressive case finding.

Similarly, because pricing policies are neither consistent nor rigorously enforced, fee charges vary widely; in many cases initial fees do not change even after long periods of treatment. In addition, there are no specific policies for fee increases, reductions, delayed payments, etc. Under these conditions the model is unlikely to reach its fullest financial potential or achieve break-even status.

There are also problems with routine program maintenance functions which can affect revenue production. Workers must keep track of patient payments and maintain their own billing or bookkeeping systems. Since worker time is limited, they cannot maintain complex record systems to appropriately monitor account balances. Rather, they prefer to simplify the problem by requesting that patients pay after each session. In addition, there is no accounts receivable system for accepting private insurance assignment payments; neither are workers systematically informed about the procedures for dealing with private insurance coverage. The result is that fees are often set at lower rates to accommodate the "pay as you go" system and any potential benefits from private insurance are, at best, minimally realized.

Another issue that surfaced, dealt with peer review and reporting mechanisms. Private social work cases do not become part of the institution's medical record system because these patients are not "technically" hospital patients. The Department of Social Work Services has a separate system for storing cases, and for monitoring private patient payments and worker contacts so that appropriate credit is allocated to the worker involved. However, because only medical record cases are selected for peer review, the private cases are excluded from an important quality assessment process. At present, worker supervision is the only available accountability mechanism for case review.

In view of the foregoing, it would appear that the Social Work Service Plan Model is not reaching its maximum functional potential at this time because it lacks the necessary administrative supportive requisites. In addition to the operational deficiencies and the lack of "product" specificity noted in this discussion, there is no evidence of promotional activity currently undertaken which might serve to broaden and enhance its development and expansion.

The model is, however, an important example of a unique, innovative, and potentially viable approach which could establish private social work services as a natural outgrowth of, and complementary component to, traditional institutional service delivery.

In analyzing the model from a design and operational perspective, it appears that the success or failure of such an approach may be largely dependent on whether the necessary supportive structures are appropriately functioning and to what degree the program is perceived as having priority by all levels of staff, in the sense of its being an integrated component of routine patient care service.

6. Geriatric Model:

The following summary of the geriatric model is based on a published description written by Hannah Lipsky and Frederick T. Sherman who are credited with its design and development.[3]

As originally conceived, the Geriatric Evaluation and Treatment Service was a private, fee-for-service program for elderly patients encountering medical and/or social problems. It was established at the Mount Sinai Medical Center in the late 1970's.

The program had two major interrelated components:

1) A comprehensive health assessment performed by a geriatrician.

2) Social work consultation and counseling services provided by a certified social worker who had special expertise in working with the elderly.

It is estimated that out of the 35,000 Mount Sinai Hospital admissions each year, 35% are 65 years or older. A large number of middle and upper class elderly are served by over 1,000 private physicians who are affiliated with the institution. The development of a private consultation service was made possible by the physician/director and senior social worker of the center who responded to the emerging need among private physicians for help with their older patients. In addition, patients and families were requesting comprehensive health care service and social work consultation and counseling in relation to changed social and physical functioning in older individuals; the effects of these changes on themselves, families and others. Thus, the three major sources for referrals were: 1) elderly patients and their families; 2) social agencies; 3) attending physicians and other health care providers.

The evaluation service included a complete medical, nursing and psychosocial assessment. These multidisciplinary evaluations were shared with the patient's primary care physician and additional planning was structured to include the patient and family in the process.

The consumers of the social work consultation and counseling component of the program were predominately elderly people living with chronic illnesses who had need for resource information and referrals pertaining to a range of concrete and residential care services. In addition, families of patients were given help with the long-term care planning needs of their relatives. Recommendations were shared with patients, families and physicians.

Charges for health assessments and social work services were based on an established fee. In a limited number of cases, the social work fee was adjusted in response to a patient request, following an evaluation of the patient/family financial situation. Fees were collected by the institution and a fixed percentage retained in return for institutional support of the program, provision and maintenance of offices, supportive service and supplies. Overhead and supplemental charges were assigned to the program and a given percentage of the earned fee returned to each of the providers.

Design and Operational Issues

The structure of the model, originally based on an association with a single physician, grew into a self contained social work service program which currently maintains collaborative relationships with many private physicians in the medical center community.

The nature of the target population served and the fee charging policies have remained essentially unchanged since the inception of the program.

The model is unique in ways which both contribute to its success but can be problematic in terms of replication. This is best illustrated by the fact that the program's successful appeal to medical providers and health consumers is closely linked to the reputation and unique qualifications of its social worker. As such, it is illustrative of a service that is primarily shaped around the reputation of a specific professional; with the result that the person and not the role or program per se becomes the basis for its attraction and marketing appeal.

For many years this social worker held a highly visible administrative position in the Department of Social Work Services that involved her with the elderly patient populations at both the clinical and policy levels. During this time she became well known to physicians who sought her help in planning for the psychosocial needs of their elderly patients. When the worker reached retirement age, a special arrangement between herself and the Department of Social Work Services was established which created a part-time social work position. The worker retained 80% of earned income with 20% going to overhead charges for office space, bookkeeping, billing, secretarial services, clerical supplies, etc.

Both parties have been advantaged by this arrangement: the department acquired a prestigious social worker to render a needed service and was able to expand its programs to include new consumer markets; the worker maintained the ability to continue to practice and earn income under the aegis of a major medical center with its inherent supports and endorsements. Such an arrangement is and must be built on a feeling of mutual trust between the individual and the institution in order for it to be operationally sound and functionally feasible. This was evidenced, for example, by the fact that the worker's salary was based on a retrospective accounting system, i.e., the worker turns all payments over to the department's bookkeeper who, in turn, determines a yearly salary based on the differential between projected and actual earnings. These practices are feasible only when a climate of mutual trust and respect is established.

Another feature of this model deals with the fact that the worker's entire salary is solely dependent on earnings generated from her practice. Operationally the model is structured on entrepreneurial principles and has achieved financial viability and self-supporting status on the basis of revenues earned.

Fee policies reflect a marketplace philosophy, i.e., "charge whatever the traffic will bear", and are comparable to rates charged by community based private practitioners; as well as institutional practices which call for flexible payment schedules and, when necessary, reduced charges.

The basis for this program's stable and steady earnings are related in large measure to its well established referral network. Referral sources include social work administrators, physicians, professional colleagues, medical center personnel, patients and the worker's personal acquaintances. Interestingly, the program does not compete for clients with the medical centers' Geriatric Clinic because it appeals to a select patient market who prefer and are willing to pay for the personalized individual care of a single specialist who practices in a private office setting.

In addition to referral sources, the worker helps to ensure continuing client participation through a variety of promotional activities which include: contacts with professional and lay community service groups and geriatric specialty organizations; formal presentations to community boards; and educating physicians and other health professionals about the program's services and benefits for elderly patient groups.

Although the worker operates with a great deal of autonomy, she is accountable to the Director of the Department of Social Work Services and discharges her professional responsibilities within the restrictions of institutional and departmental guidelines. As in the case of some of the other private models, there are no formal peer review accountability mechanisms. Cases are reviewed only when the worker determines that she needs consultation. Because the major portion of her caseload consists of non-hospital patients, they would not routinely become part of the institution's medical record system which is the entry point in the quality review process.

In sum, the key feature of this model is the fact that its appeal and acceptance is largely based on the worker and not the role she fills. While this type of situation presents problems with respect to replication and worker replacement, there are many structural features and operational strategies inherent in the program which constitute the framework for a highly successful private social work practice approach.

7. The Myasthenia Gravis Model:

The Mount Sinai Medical Center is a leading research and treatment center for Myasthenia Gravis. It has traditionally provided medical treatment and social work services for clinic patients on an ambulatory care and in-patient basis.

In 1975, the Department of Social Work Services, with the support and cooperation of the Chief of the Myasthenia Gravis Clinic and Research Laboratory, expanded the social work service programs to include myasthenic patients treated in the private medical sector. Recognizing that no social stratum is immune to the psychosocial sequelae resulting from this disease, a means was sought to implement a service program for patients who, because of their socioeconomic status, were not previously identified as needing social work support and intervention.

The social worker involved with clinic patients at the time of the program's inception, was invited to take part in the assessment and casework treatment of patients who were under the care of private physicians.

The role was designed for the purpose of making disease-specific social work services available to private myasthenic patients on a fee-for-service basis. A worker with special expertise in Myasthenia Gravis offered services to patients in two locales - within the hospital setting and in the private physician's office. Services included intakes and screenings, discharge planning, home care, rehabilitation referrals, individual and family treatment, health education and systems advocacy.

The Department of Social Work Services currently provides an office for the social worker in the medical center where she renders consultations and supportive treatment to private patients and their families during their hospital stay. In addition, a large portion of the worker's duties at the institution involve service provision to the myasthenic clinic patient population.

An "off-campus" office is provided by one of the physicians for the purpose of enabling the social worker to have contact with patients in a private medical office setting. The particular office selected is that of the Clinic Chief who also treats the majority of private patients referred into the hospital. Needless to say, when other physicians' patients are seen by the social worker in this particular setting, careful attention to physician ethics is required.

Physicians constitute the primary source of referrals for this program. The social worker requires physician consent to intervene with private patients; the degree of accessibility to patients varies among different physician practices. For example, the social worker routinely screens all new patients seen by the Clinic Chief at the time they enter either the hospital or private office system. The worker also has access to his patient charts and can recommend social work intervention based on an assessment of psychosocial risk factors.

As social work has gained exposure to and involvement with the group of private physicians affiliated with the Myasthenia Gravis Clinic, they have come to recognize the desirability of social work services for their patients - both clinic and private. Consequently, the social work role has become an integral component of a collaborative, comprehensive treatment effort which renders care to all sectors of the patient cohort population.

Social work consultation services may begin at the time of hospitalization or can occur when the physician sees the patient in his office setting. Interdisciplinary evaluations, which are a central component of the private model, enables the physician and social worker to make a comprehensive assessment of the physical and social stresses affecting patient and family functioning. Through this procedure, physician, worker and patient gain valuable insights and participate collaboratively in the assessment process and formation of the treatment plan. In instances where interdisciplinary assessment sessions with patients are not possible, background and medical information is imparted to the social worker in the course of referral who then meets with the patient and/or family to make an assessment and offer the appropriate concrete and therapeutic supports.

The model operates on a fee-for-service system. Fees are established on a sliding scale according to the patient's ability to pay. Only patients receiving service on an ambulatory basis are required to pay a fee. In-patient social service costs are automatically included as part of the third party reimbursement formula. Hospitalized patients, therefore, are not directly charged for service and often assume that it is rendered at no "apparent" cost. All income generated from social work fees is retained by the Department of Social Work Services.

The private office setting is provided rent free by the sponsoring physician. The office is accessible to the worker at all times and also includes telephone and message service at no cost. The social worker's salary, benefits and other overhead costs are assumed by the medical center.

Design and Operational Issues:

The Myasthenia Gravis model is partially self-funding. Fee charges are not firmly established on actual costs but are more typically based on sliding scale factors. The below cost pricing strategy is a result of the high cost of service and the tendency of the Social Work Services Department to adopt client fee charging policies in accordance with professional norms which are based on patients' ability to pay. Interestingly, the worker reports that most private patients are uncomfortable with the notion of fee reduction; often equating the practice with receiving charity. In a similar vein, patients have also raised questions about why they pay the medical center instead of the social worker who they view as an independent private practitioner who has medical center affiliation but is community based. It would thus appear, that they equate the worker's roles and status as being the same as the physician with whom she is associated.

In general, policies regarding fee charges are not clearly defined; in this sense the private model is less consistent in its approach to this matter than are the hospital clinics. Looking at the fee issue historically, it is of interest to note that when the model first began, the Muscular Dystrophy Association (MDA) paid a flat fee for social work services for private patients. This was part of MDA's effort to expand their role in the field of neuromuscular diseases and become involved in patient support services, in addition to their research interests. After several years, MDA withdrew their financial support as part of a comprehensive fiscal cutback program and, as a result, the number of patients participating in the private Myasthenia Gravis Social Work Program declined. This fact has led the staff to feel that the availability of reimbursement or cost sharing mechanisms make a significant difference in patients' willingness to utilize the service.

While the establishment of fee and other administrative policies are clearly under the direction of social work department administrators, certain aspects of operational policies dealing with direct service delivery, i.e., screenings, type of service rendered, are established through a collaborative process involving social work administrators, the private physician - specialists, and the Myasthenia Gravis social worker.

Similarly, the worker's accountability for patient care is divided between administration and the private physician. Cases are reviewed by administrative supervisors for purposes of teaching and maintaining quality standards. At the same time, there is on-going communication and feedback between the physician and worker regarding patient and family needs and case planning. Other forms of accountability include chart notes, departmental statistics for hospitalized and non-hospitalized Myasthenia Gravis social work patients, and monthly statistics on new myasthenic patients with a brief assessment on why they did or did not engage in service.

From the point of view of administrative supports, the Department of Social Work Services allocates funds to maintain this program which is only partially supported by fees. In addition, this model has a number of unique features which enable the worker to function in two locales and help to create a job that is interesting, challenging and prestigious. For example, the worker is permitted to carry a reasonably small caseload (as compared to other services) which implicitly emphasizes the concept of quality as opposed to that of quantity. She also has coverage readily available for those times when she is out of the hospital and seeing patients in the physician's private office. Administration also pays for taxi fare so the worker may travel between the two locales with a minimum of discomfort or time loss. From another, less tangible, perspective, the importance of this program to the social work department, together with the uniqueness of the job position design and its special association with attending physicians, has resulted in the position becoming a prestigious one with the worker benefiting in terms of job conditions, responsibilities, experiences and professional status.

As this specialized private practice model has become established in the social work and medical communities over the years, its referral network sources have expanded. Although physicians still constitute the primary source for referrals, e.g., all new myasthenic patients in the Clinic Chief's private practice are automatically referred for social work screenings, other sources such as patients and professional colleagues have begun to make referrals. A particularly interesting and recent referral agent is the Muscular Dystrophy Association which still maintains an active interest in Myasthenia Gravis. Through connections with the MDA service representative, patients are being referred to the Mount Sinai private social work program from hospitals that treat myasthenia but lack the services of a social worker with special expertise in the illness. Since this is a relatively new development involving a small number of patients, the politics and ethics of such a situation have not, as yet, been worked out. In addition to the MDA Foundation referrals, the Myasthenia Gravis Foundation which has its national headquarters and regional chapter offices in the New York City area, has referred patients who inquire about help with problems of a non-medical or psychological nature.

The worker's participation in the Myasthenia Gravis Foundation conferences, conventions, and fund raising affairs, constitute key promotional activities which have made her known to many patients and enhanced her credibility as a specialist in that field of practice. The fact that she was initially introduced to these community organizations by physicians may have helped to accelerate her acceptance and legitimation as a valued professional who is part of the treatment team.

Specific promotional activities have ranged from initially attending chapter meetings and patient functions on an informal basis, to participating as a scheduled speaker at medical seminars and lay conferences.

In sum, this model's success would appear to be attributable to such factors as the existence of an identifiable patient population whose needs require psychosocial services, and the availability of physician and institutional supports which result in functional structures that enhance worker motivation, increase productivity and maintain quality in service delivery.

This model is illustrative of the collaborative principle both from an interdisciplinary point of view which seeks to offer comprehensive patient care, and from a perspective of institution and community medical practice associations which permits hospital-based social work departments to establish formalized linkages with private physicians through the provision of institutional services.

In assessing the model from the point of view of its weaknesses as well as strengths, it was noted that a highly specialized practice may be limited in terms of actual numbers of potentially participating patients because the nature of the specialization is narrow while the geographic distribution of patients is wide. There are also problems with establishing on-going or long-term social work treatment, which can be the foundation of a private practice, because of the variability inherent in the illness. For example, remissions can exacerbate denial of problems; relapses can interrupt treatment or result in too much incapacitation to participate.

With regard to accountability, the worker has to cope with the pressure and stress of answering to multiple "masters" whose objectives and priorities may not always correspond. In addition, when disease-specific patients are hospitalized, they are often in many locales throughout the institution, depending on the nature of their problem, bed availability, etc. The worker, therefore, cannot establish her or himself with a single service but, rather, must create contacts and credibility in multiple settings with multiple disciplines in order to gain the cooperation necessary for meeting patient needs.

As with other private models, patient records do not become part of the peer review process, unless a patient is hospitalized. In addition, it also lacks accounting and bookkeeping supports which limits ability to deal with third party payments, follow-up billings or partially paid balances.

B. ANALYSIS OF CONSUMER SURVEY DATA: REPORT OF RESULTS

Description of Sample Population

The patients surveyed ranged in age from 18 - 85; the median age of the group was 46 - 55(see Table 1). Approximately 60% were female (Table 2) and over 90% were Caucasian (Table 3); the latter factor reflecting the nature of this particular private practice. For the most part, patients had intact families; more than two-thirds of the repondents were married (Table 4), and 40% had dependent children living at home (table 5). With respect to occupation, the group was fairly evenly distributed among the categories of homemaker, professional, blue collar worker and retiree (Table 6). This was also a well educated patient group with 35% graduating from high school, 30% attending college, and 23% having graduate level educational experience (Table 7).

The majority of patients had mild to moderate symptomatology, with only 19% experiencing a severe form of the disease (Table 8). One-third of the sample were recently diagnosed; over 50% were diagnosed over a decade ago (Table 9).

In sum, the sample population was a white, middle/upper-middle class group, who were evenly distributed among the sexes, averaged around 50 years of age, and, for the most part, had intact families. More than one-half had gone to college and were employed as professionals or craftsmen; with a large percent falling into non-working categories. On the whole, this was a fairly well group of chronically ill patients who had lived with their illness over a considerable period of time and had minimal to mild physical impairment.

Patient's Ratings of Service Components

The following services were regarded as being most important by 73% or more of the population:

Information on benefits
Assistance with medical treatment
Providing letters
Information on community resources
Help with medical problems
Help with reactions to illness
Help with mood changes

(See Tables 11, 14, 15, 17, 19, 20, 21)

The services perferred most reflected a combination of concrete needs and psychological supports to enhance coping with the impact of illness.

None of the services received a rating of unimportant by more than 50% of the population. Those that were, however, rated as unimportant by the greatest percentage of respondents were:

Assistance with Homecare
Help with home modifications
Guidance for educational problems
Help with sexual functioning
Help with social/interpersonal problems
Help with family problems

(See Tables 12, 13, 16, 22, 23, 26)

The choices tend to reflect the wellness of the population; and the fact that their overall functioning was only minimally to moderately impaired.

Patient's Ratings of Service Features

There was little variance among the ratings for the different service features. Those rated most important by 80% or more of the population were:

Prompt service
Same provider
Cost of service
Availability of insurance
Location
Atmosphere
Certified provider
Physician recommendation
Confidentiality

Home visits and credit card acceptance were rated as being the least important features (See Table 28).

Factor Analysis

The items in Part A and B of the questionnaire were subjected to factor analysis to determine which service components or features correlated with each other. Those items that clustered together became a factor.

Part A

In Part A three factors were identified:

Factor 1 was comprised of concrete and psychological support services. The common elements could be characterized as "coping with illness: concrete and psychological". Specifically, it included the following items:

Information on benefits

Assistance with obtaining medical treatment

Providing letters

Information about community resources

Help with management of illness

Help in coping with medical problems

Help with dealing with reactions to illness

Help with mood changes

Factor 2 was comprised of psychological support services. The elements could be characterized as "psychotherapeutic services: individual and family". It included the following items:

Providing educational guidance
Help with problems in sexual functioning
Help with interpersonal problems
Help with work related problems
Treatment for emotional problems
Help with family problems
Helping family members cope

Factor 3 consisted exclusively of concrete services and could be characterized as "resource needs". It included the following items:

Information about medical aids
Assistance with home and health supports
Help with planning housing modifications

Part B

In Part B four factors were identified:

Factor 1 could be characterized as "service accommodations" and was comprised of the following elements:

Availability of prompt service

Evening office hours

24 hour coverage

Home visists

Service with same provider

Provider affiliation

Factor 2 could be characterized as "cost factors" and was comprised of the following elements:

Cost of Service
Flexible payment schedules
Credit card acceptance
Availability of insurance coverage

Factor 3 could be characterized as "locale features/legimation" and was comprised of the following elements:

Convenient location
Pleasant atmosphere
Physician's recommendation

Factor 4 consisted of two elements and could be characterized as "confidentiality/provider credentials":

Licensed professional
Privacy and confidentiality

Consumer Familiarity and Intent to Utilize

The degree of consumer awareness of the program and their potential utilization of service were examined. Only 17% of the respondents said they were very familiar with the social work program.

"Somewhat familiar" (47%) was the most common response, and 35% stated they were unfamiliar with the program (Table 29). Slightly more than one-half of the sample indicated they would probably utilize the service, and 87% indicated interest in a brochure that would provide detailed information about the program (Tables 30, 31). With regard to consumer experience with similar services, 93% reported that they were not presently engaged in counseling or psychotherapy, and approximately two-thirds had no prior mental health service experience (Tables 32, 33).

In general, this market would appear to be comprised of an uninitiated clientele who had little or no familiarity with the program. While they do show interest in potentially using the service, they clearly require more clarification about it.

Social Work Service Consumers:

Sub-group Analysis of Myasthenia Gravis (MG) Program Participants

Out of 100 respondents, there was a penetration rate of 18 cases that had participated in the MG Social Work Service Program. Of this group of service users, 83% learned about the program from their physician, and 72% stated that the physician's recommendation influenced their decision to utilize service (Tables 34, 35).

In 63% of the cases, the service was rated as being very helpful; only 6% rated it as not at all helpful (Table 36).

More than half the respondents indicated they would definitely use the service in the future, and nearly one-quarter stated they might use the service again (Table 37).

Finally, almost 90% of the patients were willing to recommend the service to other patients; with the remaining percent indicating that they would probably recommend it (Table 38).

Overall, the responses of service users pointed out the importance of the physician's role in facilitating referrals and influencing utilization, and indicated an overwhelmingly positive reaction to the service experience.

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CHAPTER VI. CONCLUSIONS AND RECOMMENDATIONS

A. PRIVATE FEE-FOR-SERVICE SOCIAL WORK MODELS

Summary and Implications

As a result of the private model survey, seven distinct institutionally based practice arrangements were identified and examined. The analysis serves to acquaint social work administrators and practitioners in health care settings with a broad range of fee-for-service program options; their inherent marketing potentials and limitations.

In line with these objectives, a typology was developed which can be used to classify medical practices according to their parameters, foci and type of patient populations served.

Such classification will enable the administrator and practitioner to differentially assess institutional and community based medical practices on the basis of their consumer characteristics and needs, service requirements, and revenue producing possibilities. This type of analysis, in turn, permits determination of potential for private social work program development.

From a different perspective, the implications of the data were examined with an eye toward programmatic revisions that would improve the functional aspects of the models under study. Among the areas that warrant further attention are:

1. Accountability Mechanisms:

   a) Administrative Reporting System -

   Under the present system, workers seek consultation or supervision for their private, fee paying clients on an elective basis. Because there is no systematic review of cases, workers monitor their own accountability.

   A more stringent policy is needed to insure that cases receive a reviewed opinion. Since the degree of experience and knowledge among workers tends to vary, stricter enforcement of case supervision should be required in order to maintain acceptable practice standards.

   b) Peer Review -

   Because private social work patient charts are not included in the medical record system, they fail to go through routine assessment procedures. Development of a seperate accountability mechanism for private case review, would help to insure that appropriate standards for quality case management are carried out.

2. Revenue Production:

   In most cases, the models were not achieving their maximum financial potential. This situation could be improved by establishing case quotas rather than depending exclusively on the worker's initiative to develop a private caseload.

   In addition, establishment of standardized fees and enforcement of consistent pricing policies, would help increase and stabilize revenue production.

3. Administrative Supports:

a) Bookeeping and Accounting Supports -

Reliance on workers to maintain their own accounting and billing systems has resulted in lost revenue because workers lack the time and expertise to appropriately administer these tasks. By providing bookkeeping supports to monitor account balances and issue patient bills, third party payments, delayed or partial payments, and unpaid balances could be managed more efficiently and effectively. If patients did not have to render payments after each session and were able to utilize insurance benefits or pay out balances over time, then higher fees and flexible payment schedules could be established.

b) Training Seminars -

Staff seminars should be resumed. Their purpose would be to legitimate private practice services, encourage worker participation, and provide the necessary training for dealing with the practical and ethical issues of serving a paying clientele.

4. Worker Motivation:

In models where private cases are carried on an elective basis and are not part of routine responsibility, incentives became an important issue.

Presently, incentives consist of the opportunity to have a varied caseload mix and generate income for the Department. Such incentives do little to promote and motivate worker participation.

If, however, workers could directly benefit from revenues they generate, they might seek to actively expand their caseloads.

Incentives could take a monetary form such as percentage of earnings, or could be translated into a "perk" such as subsidizing attendance at a professional conference of choice. Any number of benefits could be designed which would be supported by earnings produced from private, fee-for-service patient contacts. Of course, appropriate mechanisms should be instituted for monitoring these activities so that they do not compromise the service rendered to non-fee paying clienteles.

5. Promotion:

The promotional strategies employed in the MG and Geriatric models consisted primarily of public speaking activities targeted at professional and lay community groups.

Additonal methods for publicizing the programs include: brochures for providers and consumers, letters to physicians informing them of the role and function of social workers in private practice settings, meetings with physicians to define potential markets and assess their practices for programmatic potential.

In addition to examining functional structures and program features, this study also identified a number of ways in which fee-for-service models can benefit social work departments in health care settings. For example, participating in the private service model could constitute a form of vertical/lateral mobility for workers in systems where few opportunities for promotion exist. Such "advancements" would need to include tangible rewards (incentives), analogous to promotional titles and salary increases, that would satisfactorily compensate workers.

Additionally, revenues produced from private service models can be used to provide funds for programs serving disadvantaged patient populations where viability is threatened due to insufficient financial resources.

Finally, surplus revenue generated by client fees can be applied toward sponsoring a variety of departmental activities. As an example, the social work department fund at Mount Sinai, which is largely financed by private client fees, supports a range of educational and service oriented activities. Specific examples include: membership dues for faculty members, purchase of professional literature for the staff library, guest speaker and consultant fees, funding for social occasions, e.g., holiday and retirement parties.

Funds have also been applied toward start-up costs for new programs. In one case they were used to initiate a computer program prior to obtaining full funding; in another they helped to temporarily support a new social work position until permanent funding could be established.

In conclusion, based on the preliminary findings of this study, it would appear that the development of private, fee-for-service models can have positive implications for social work's growth and expansion in the health care arena. Private service models help to expand the practice domain of institutional social work departments by enabling them to provide service to new client markets within health care settings, and extend established services into community based private medical practices.

The study also suggests that the following requisites are needed for optimal program functioning:

1. A definable market with identifiable psychosocial needs
2. Physician support and sanction
3. Administrative supports
4. Incentives to motivate worker participation and productivity
5. Accountability mechanisms
6. Standardized fee charging policies
7. Organized promotional activities

B. CONSUMER SURVEY ANALYSIS

Summary and Implications

This study represents an approach to analyzing and understanding service design and delivery from a marketing perspective. It seeks to determine what chronically ill patients need and want from a private social work service health care program. Specifically, it examined the needs, preferences, perceptions, and satisfaction of Myasthenia Gravis (MG) patients. The results of the study contribute to our knowledge about marketing private social work service health care models and provide a basis for expanding current programmatic efforts.

Although the findings must be considered tentative due to the limited sample size, they support the notion that chronically ill patients, treated in the private medical sector, have psychosocial requirements and would utilize and pay for social work support services if they were appropriately suited to their needs. Examination of data showed that, in almost all the cases, patients related to some type of service need. It is significant that the service preferences identified by this group of patients were a combination of concrete and psychological supports resembling conventional social work service as it is practiced in the health care field. This would seem to imply that the social work product, as it has been traditionally packaged in health care settings serving underprivileged groups, has appeal and utility for consumers in the private health care market.

It was also noted that respondents not only related to the prespecified list of services presented in the questionnaire, but recommended others as well that could serve to broaden the structure of the MG social work role. These included:

- Conducting patient education seminars about research and treatment developments
- Group counseling in addition to individual treatment
- Providing consultation to self help groups and linkages among patients in the same geographic area
- Referral services for counseling in locales throughout the country
- Training seminars for mental health professionals in other geographic locales concerning the management and treatment of psychosocial problems in specific illness groups
- Vocational evaluation where disability necessitates job change
- Routine social work consultation for patients and families at time of diagnosis and at annual medical examination

Such specific service requests are indicators of patient interest and need. These expanded role functions, which reflect the needs and desires of the target market, represent product modifications that can enhance appeal and broaden market response. In addition, most of these functions have inherent potential for generating revenue, if structured and priced as independent service entities.

Another important finding dealt with the factor analysis and resultant identification of service clusters. These factors represent distinct service packages which can be marketed on the basis of their suitability for particular patient groups. For example, because elderly patients often require assistance with resources, they might be inclined to use a service that offers information and referral assistance. On the other hand, young single people and families might be attracted to a psychotherapeutic type of service program. Services can be packaged and marketed to physicians based on the special needs of their patient populations. Thus, by applying the concept of specialization, one can offer a limited set of services to a limited market.

The notion of service packages also enables social workers to explicitly define service programs for consumers and providers, rather than relying on vague definitions which only confuse, rather than enlighten, potential users. The objective is to emphasize product specificity and thereby highlight the attributes of the service that will maximize its attactiveness to its clients. In this sense, the basis for appeal should reflect the complementary fit between the consumer's unique needs and the product's specific attributes.

This concept agrees with Stratmann's contention that market behavior which guides the choice of health care services results from cognitive trade-offs among various sets of decision components. Consumers tend to utilize the source of care that is calculated to have the greatest perceived value. It also reflects Friedson's hypothesis that service utilization may depend on whether the service matches the patients requirements and their perceptions of the provider's role and function.

Consumers ratings of service features constituted another dimension of the study. Analysis showed that terms of service delivery, physical environment and provider credentials were all important to consumers in their evaluation of a source of care. This supports Fizdale's experience (Arthur Lehman Counseling Service) in competing with other mental health disciplines where factors such as office location and ambiance, conditions of service, and professionalism proved to be critical to success.

Conceptually, these components, when combined with the range of services offered, provide a useful framework for understanding the multitude of factors that consumers consider when selecting a service resource. It should be noted, however, that the features identified in this study are probably not exhaustive and may differ from those that might emerge in another population.

When consumer product awareness and utilization potential were examined, several significant findings emerged. First, the consumer sample proved to be an uninitiated market with little prior product (counseling) experience. Furthermore, because over 80% of the respondents had little or no familiarity with the program, it can be concluded that they could use more knowledge (familiarity with) about it. Second, the data showed that the program has market potential, and that there is sufficient utilization interest among respondents. Patients who were inclined toward utilizing the service indicated that it could be helpful during times of personal crisis or when their illness worsened. This group also saw it as enabling them to cope more effectively with the emotional problems and day-to-day management issues connected to the illness. In contrast, patients who were not interested in utilizing the service found it to be either geographically inaccessible or unnecessary due to satisfactory adaptation and adjustment.

These findings imply that newly diagnosed patients and those who are experiencing medical or personal crisis would be most receptive to receiving service. Of the patients that live in close proximity to the program, those that have adapted to their illness or are in remission would be least likely to utilize the service. It is of interest to note that only 1% of the cases identified cost as a determining factor in choosing whether or not to utilize service.

Third, and last, the overwhelming majority of patients desired additional information about the program. If this sample is representative, one could surmise that most private patients are unclear and uncertain about the functions of a social worker in a private medical practice setting, but are interested in learning more about it. As such, they constitute an uninformed group of potential product users.

Consumer uncertainty is a basic marketing issue for providers of professional services. Where there is a lack of information, people can remain unsure if they need the service or dissatisfied if they use it and it fails to meet exaggerated expectations.

In order to reduce consumer uncertainty, professional services must emphasize education rather than persuasion in their marketing. For example, MG patients could benefit from a brochure that teaches them about the following:

- When they should seek professional service
- Which services are available and on what terms
- Who will render the service (provider's credentials, skills, etc.)
- How to contact the service provider

- How the service can benefit them

Because such an approach imparts an understanding of patients problems and provides them with the factual information needed to make an informed decision, it can stimulate interest and confidence in the product.

In addition to querying prospective consumers about their preferences and attitudes toward the sevice program, the study also looked at the perceptions and reactions of MG service users.

An important finding to emerge from this sub-group analysis is that the physician has considerable influence on the utilization decision. The physician was not only seen as being the primary source of information about the program but, through his endorsement and support, influenced patients to utilize it as well. This would tend to support Beloff and Korper's findings which showed that the provider's philosophy of care can be a key determinant in influencing type of service utilized and in creating a demand for services offered. Thus, because the physician plays a critical role in promoting the service, his or her collaborative involvement in the marketing plan would seem essential to insuring program success. When analyzing respondents' high degree of satisfaction with the service experience; and their willingness to use it again, it appears significant to look at the reasons given. Positive experiences were associated with help received during and after hospitalization, and at times when the illness worsened. It was also associated with patient outcomes such as increased self esteem, decreased fear and anxiety; or with the process itself, i.e., beneficial contact with a caring and helpful person.

Only 6% of the patients reported a negative service experience. Reluctance to use the service again was attributed to a lack of need, a negative prior experience, or the geographic inaccessibility of the program.

Based on these results, one can hypothesize that the critical entry points for social work intervention may occur around hospitalization or exacerbation of illness. This is compatible with what we know about the psychological consequences of illness, i.e., its dysfunctional effects on self esteem and coping mechanisms and the fact that people are more amenable to help during periods of crisis. In keeping with this frame of reference, time of diagnosis would constitute another critical entry point for intervention.

With respect to the treatment process itself, the empathy of the provider was seen as having a positive effect on patient response. It is possible, therefore, that both the timing of intervention and the empathy of the provider are factors which may influence patients' reactions to and utilization of social work services.

In looking for additional indicators of satisfaction, patients were asked if they would recommend the service. Product recommendation is not only an indication of consumer satisfaction but is also an important mechanism for generating new business.

The study group's unanimous consent to recommend the service to other MG patients infers that all the respondents in the sample found it useful on some level. When asked about the reasons for recommendation, they made reference to the fact that it helped their adjustment to illness by providing emotional support and educational information, and enabled families to better cope with the tasks, feelings and problems that arose as a result of the illness.

Thus, for this population of service users, the availability of a social worker in a private medical setting is viewed as a positive component of the care process that has inherent benefits for the individual and his or her family. This tells us that, based on the opinions of a group of patients who have used the product, it does have utility and appeal for the market it seeks to serve.

Summary of Study Findings

It is believed, that the findings presented here have important implications for marketing private social work health care models in general, and disease-specific models, most particularly. To briefly summarize key points, the study has identified:

1. A potential market for the MG service model -which may be an indication that, on a broader level, the private health care sector represents a significant and untapped market for social work program development.

2. A demand for social work service, as it is traditionally practiced in health care institutions, by a new private medical patient market - which would imply that social work, as a marketable product, has appeal and utility for all socioeconomic groups.

3. The importance of physician involvement in insuring a successful marketing campaign because of their pivotal role with patients in promoting and sanctioning social work service utilization.

4. The concept of social work service health care program "packages"; their implications for utilization by limited markets that are attracted on the basis of product specificity (specialization).

5. The fact that consumers do seem to evaluate program features as well as services when considering a source of care - such data has implications for all social classes and has not been adequately addressed by social program planners.

6. The fact that private patients seem to be relatively unfamiliar with the social work role in medical practice settings and, therefore, may constitute an interested but uninformed group of potential product users.

7. The need for product promotion strategies that will educate health care consumers about private social work services and when and how they can be best utilized.

8. Product modifications in the form of alternate service approaches for generating program revenues - the intent being to broaden established roles based on specific target population needs; thereby enhance market response.

9. Which types of consumers are likely to be most/least interested in using service, e.g., service may be useful for patients in medical or personal crisis, but not for those who have adapted over time or are in remission.

10. What factors are possibly associated with a positive service experience, e.g., help received during hospitalizations and at times of medical crises, and what are some of the benefits derived, e.g., increased self esteem and decreased fear.

All of the above constitute areas for future study and exploration.

Study Limitations

Although this study did, for the most part, satifactorily meet its intended goals and objectives, there were a number of inherent limitations. To begin with, the sample representation was distorted because it consisted of only one year's trial period involving the practice of a single physician. It is not, therefore, representative of the whole population. Also because of the limited sample size, the numbers were not sufficient for making quantifiable projections to the total universe.

Another problem concerning the study sample pertained to the limited number of service users. While the penetration rate of users in relation to the total population looked high (N=18), it actually represented a time span of ten years. There was no way to determine, therefore, if social work was properly or under utilized. In addition, we could not compare user and non user service needs and preferences because the numbers did not lend themselves to statistical analysis. Further exploration of these issues with larger population samples is warranted, if we are to understand what leads to effective social program marketing.

There also proved to be problems with the questionnaire design; particularly those questions pertaining to head of household. For example, working wives had trouble with this group of questions because they saw themselves as co-heads of household. Husbands also acknowledged their wives' financial contributions. It appears from these responses that the Women's Movement has strongly impacted on this issue and that this standard type of marketing question needs to be re-evaluated in light of recent social trends. As a result of unanticipated respondent reaction, head of household questions were eliminated from the final results and we were unable to determine the number of income producing members in a patient family. Similarly, the question related to number of persons living in household proved to be ambiguously worded and was ultimately discarded.

Finally, although we did attempt to segment the market according to sociodemographic variables, no statistical differences could be established with regard to service preferences among the sub-groups of the population. When the mean scores for the groups were compared, the numbers proved to be too small to determine any significant differences. We were unable, therefore, to prove a central hypothesis of the study which was that disease-specific private patients who comprise a discrete market, as defined by a common illness and treatment setting, would respond differentailly to a social work service program. Although we did ascertain the needs, preferences and perceptions of the study group as a whole, we do not know whether the various segments of the market differed in their attitudes or what their specific service priorities and requirements were. Such analysis would constitute another important phase of further study.

Conclusion

This presentation examined the impact of chronic illness on middle class health consumers; their growing need for social health support services. It addressed social work service's engagement of a middle class population with chronic illness and assessed currently operative institutionally based service delivery models, from a consumer oriented marketing perspective.

It was the purpose of this study to contribute to a relatively new area of social work practice in health care by identifying and describing a range of private social work service models operating under institutional auspices, and by developing an approach, based on marketing principles, for designing and promoting such models.

The study was distinct in that it applied principles of marketing and consumer utilization theories to the task of assessing social work program design and delivery; utilizing the concepts of product, price, place and promotion. It represented an initial attempt to classify various types of practice arrangements found in institutionally based private social work models, and examine in-depth, a single operative model that evolved in a highly specialized private medical practice setting serving middle class, chronically ill patients.

The approach employed in this study rests on the underlying belief that program appeal and utilization can be enhanced by using consumer judgments as an intrinsic part of the planning and evaluation process. It assumes that consumers will utilize professional service if it satisfies their interests and conforms to their norms and expectations.

It is believed that the proposed strategies can be applied to range of service models and target populations where there is a definable market with multiple service needs. As such, it has important implications for expanding program efforts, engaging new client markets, and competing effectively with other mental health professionals in the open marketplace. This is particularly relevant at a time when the profession must seek out new markets for its services and is experiencing an expansion of third party insurance coverage which can result in new resource potential for program support.

In conclusion, it is believed that this presentation will contribute to our knowledge about how consumers select a service; what they need and want from a private social work health care program. At a broader level, it combines service provision concepts and marketing strategies to create programs that are responsive to patient needs, capture their interest, and motivate participation. Such an approach serves as a framework for planning new program content and direction and evaluating the effectiveness of established program trials.

In line with the foregoing, one hopes that this research will stimulate further exploration into a new and promising area for social work in health care and serve as a first step in a sequence of research activities to determine how commercial marketing theory can be suitably adapted for social work program development.

STAFF QUESTIONNIARE
Survey of Private, Fee-for-Service Social Work Models
Mount Sinai Medical Center
Fall 1984

I. HISTORICAL DEVELOPMENT AND BACKGROUND

A. How the Model Began
  1. Who originated the concept
  2. What motivated the idea
  3. How was it implemented
  4. What supports were needed to make it possible
    a. Administrative
    b. Financial
  5. Who was served initially (target population)

II. CURRENT MODEL: DESIGN AND OPERATIONAL ISSUES

A. Financial
  1. How is it financed
  2. Fee System
    a. How was fee system established
    b. Who does billing and how (bookkeeping system)
    c. Fee range (fixed or sliding scale)
      1) Screening mechanisms
      2) Flexibility
      3) Average fee charged
    d. Collection policies
    e. Fee arrangements between worker and institution
      1) Who does the patient "pay" (name on check)
    f. Amount of income generated from private, paying patients

      1) Self pay and/or 3rd party private insurance

B. Administrative
  1. Who is responsible for program operations
    a. Policy
    b. Implementation
  2. What administrative supports are given
  3. Accountability
    a. To whom is it accountable
    b. What are the accountability reporting mechanisms
    c. Who keeps patient records
      1) Financial
      2) Case contacts

C. Location
  1. Where is the program located
  2. Where is service rendered

D. Patient Population
  1. How do patients come into the system
    a. Referral sources
  2. Types of patients seen
    a. Needs/problems

E. Components of Service
  1. Monthly case volume
    a. Number of referrals
    b. Average number of contacts
    c. Size of active caseload
  2. Type and range of service offered
    a. Long term, short term, crisis intervention
  3. Percent of worker time spent in the program
  4. Full or part time position
  5. Specialized or generic social work service

F. Promotional Strategies
    1. With whom it is promoted
    2. What promotional activities are planned
    3. How do patients and providers hear about the program

G. Assessment of the Program
    1. Strengths/Weaknesses
        a. What makes the model work
        b. What are the problems with it
        c. Suggestions

MYASTHENIA GRAVIS PATIENT QUESTIONNAIRE

This questionnaire pertains to the Myasthenia Gravis Social Work Service Program. The intent of the study is to better understand patients' needs and attitudes toward this type of service. The questionnaire will take only 15 minutes to fill out. Your name will in no way be connected with it.

Please return it in the enclosed self-addressed envelope no later than May 15.

____ (1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 1

A. Sometimes, illnesses like Myasthenia Gravis can cause problems for patients and their families. The services listed below are based on a range of problems which patients and/or family members may occasionally experience. We would appreciate your rating these items according to how important they are to you.

PROCEDURE:

Please rate each of the items listed below from 1 - 5 by circling the number which is applicable.

1 = Very Important
2 = Somewhat Important
3 = Somewhat Unimportant
4 = Very Unimportant
5 = No Opinion

For clerical use
Do not complete

1. Information about medically recommended aids (appliances, equipment, etc.).

1 2 3 4 5 ____ (4)

2. Information on benefits and entitlements (financial planning, medical coverage, social security, etc.).

1 2 3 4 5 ____ (5)

3. Assistance in obtaining home and health supports (nursing services, homemakers, babysitters, etc.).

1 2 3 4 5 ____ (6)

4. Help in planning housing modifications (special bathroom facilities, inclinators, etc.).

1 2 3 4 5 ____ (7)

5. Assistance with obtaining on-going medical treatment (plasmapheresis, doctor's office visits, etc.).

1 2 3 4 5 ____ (8)

6. Providing letters and reports for agencies, insurance companies, etc.

1 2 3 4 5 ____ (9)

7. Providing guidance for educational, vocational or recreational problems.

1 2 3 4 5 ____ (10)

8. Information about community organizations, agencies and services for Myasthenic patients.

1 2 3 4 5 ____ (11)

(1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 2

9. Helping with the management of the illness (information on meal preparation, etc.)

1 2 3 4 5 (12)

10. Help in coping with medical or service related problems.

1 2 3 4 5 (13)

11. Help with dealing with reactions to the illness, medical procedures, treatment, prognosis.

1 2 3 4 5 (14)

12. Help with mood changes such as feelings of low self-esteem, irritability, etc.

1 2 3 4 5 (15)

13. Help with problems in sexual functioning.

1 2 3 4 5 (16)

14. Help with social or interpersonal problems resulting from the illness.

1 2 3 4 5 (17)

15. Help with work related problems resulting from the illness.

1 2 3 4 5 (18)

16. Providing treatment for emotional problems related to anxiety, stress, depression, alcoholism, drug abuse, etc.

1 2 3 4 5 (19)

17. Providing help with family problems (marital, parent/child, school problems, child care arrangements, etc.).

1 2 3 4 5 (20)

18. Helping family members cope with the impact of the illness.

1 2 3 4 5 (21)

19. Please suggest any additional services which you feel could be of benefit to Myasthenia Gravis patients and their families.

____

____

____

____

____ (22)

(1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 3

B. If you were to consider seeking professional help for any of the problems mentioned above, how important would the following factors be in selecting a source of care?

PROCEDURE:

Please rate each of the items listed below from 1 - 5 by circling the number which is applicable.

1 = Very Important
2 = Somewhat Important
3 = Somewhat Unimportant
4 = Very Unimportant
5 = No Opinion

1.	Availability of prompt and immediate service	1	2	3	4	5	(23)
2.	Evening office hours	1	2	3	4	5	(24)
3.	24 hour phone coverage	1	2	3	4	5	(25)
4.	Home visits	1	2	3	4	5	(26)
5.	On-going service with the same provider	1	2	3	4	5	(27)
6.	Cost of service	1	2	3	4	5	(28)
7.	Flexible payment schedules	1	2	3	4	5	(29)
8.	Credit card acceptance	1	2	3	4	5	(30)
9.	Availability of insurance coverage for fees	1	2	3	4	5	(31)
10.	Convenient location	1	2	3	4	5	(32)
11.	Pleasant atmosphere (quiet, attractive, clean)	1	2	3	4	5	(33)
12.	Licensed and certified professional provider	1	2	3	4	5	(34)
13.	Physician's recommendation	1	2	3	4	5	(35)
14.	Provider is affiliated with same medical center as your physician	1	2	3	4	5	(36)
15.	Privacy and confidentiality	1	2	3	4	5	(37)

16. What additional factors would you consider to be important?

(38)

(1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 4

C. For the past eleven years, the Myasthenia Gravis social worker has helped patients with the types of problems we have described.

The next group of questions are concerned with your awareness of this service and potential interest in using it.

1. Check the statement that best describes your familiarity with the social service program.

( ) Know very well
( ) Know a fair amount
( ) Know just a little bit
( ) Heard of
( ) Never heard of

(39)

2. a. How likely is it that you or a family member will utilize this service?

( ) Definitely will
( ) Probably will
( ) Might utilize it
( ) Probably will not
( ) Definitely will not

(40)

b. Would you please explain your answer.

____
____
____

(41)

3. If we were to prepare an informational brochure on this service, do you think it would be of value and interest to Myasthenia Gravis patients?

( ) Yes ( ) No ( ) Maybe

(42)

4. Are you currently using psychotherapeutic or counselling services?

( ) Yes ( ) No

(43)

5. Have you ever used psychotherapeutic or counselling services?

( ) Yes ( ) No

(44)

D. The following group of questions will be used for statistical purposes only. Please check the statement that is applicable.

1. What is your age?

( ) 18 - 25
( ) 26 - 35
( ) 36 - 45
( ) 46 - 55
( ) 56 - 65
( ) 66 - 75
( ) 76 - 85
( ) Over 86

(45)

2. What is your sex?

( ) Male ( ) Female

(46)

(1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 5

3. To which ethnic group do you belong?

( ) White
( ) Black
( ) Asian/Pacific Islander
( ) American/Alaskan Native
( ) Puerto Rican
( ) Mexican American
( ) Cuban
( ) Other Hispanic
( ) Other (specify) ____________

(47)

4. What is your marital status?

( ) Single
( ) Married
( ) Separated
( ) Divorced
( ) Widowed

(48)

5. Persons living in your household (check all that are applicable).

( ) Spouse
( ) Relatives
( ) Children
( ) Other (specify) ____________

(49)

6. Number of children living at home?

( ) None ( ) One ( ) Two ( ) Three or more

(50)

7. What is your present occupation?

( ) Homemaker
( ) Physician/Dentist
( ) Professional/Technical
( ) Upper Mgmt./Administrator
( ) Craftsman/Tradesman
( ) Clerical/White collar
( ) Sales/Services/Middle Mgmt.
( ) Retired
( ) Student

(51)

8. Length of time at present occupation? ____________

(52)

9. a. Are you the head of a household?

( ) Yes ( ) No

(53)

b. If you are not, what is the occupation of the head of the household?

( ) Homemaker
( ) Physician/Dentist
( ) Professional/Technical
( ) Upper Mgmt./Administrator
( ) Craftsman/Tradesman
( ) Clerical/White collar
( ) Sales/Services/Middle Mgmt.
( ) Retired
( ) Student

(54)

10. Head of household's length of time at present occupation? ________

(55)

11. What is the highest level of education you have completed?

( ) Elementary school
( ) Junior High school
( ) High school
( ) Trade/Vocational school
( ) 1 - 2 years of college
( ) 3 - 4 years of college
( ) More than 4 years of college

(56)

(1-3)

MYASTHENIA GRAVIS QUESTIONNAIRE PAGE 6

E. This last group of questions concerns only those patients who are currently using the services of the Myasthenia Gravis social worker, or have done so in the past.

1. How did you hear about the services? (check all that are applicable)

( ) Physician
( ) Hospital staff
( ) Other Myasthenic patient
( ) Myasthenia Gravis Foundation
( ) Muscular Dystrophy Association (MDA)
( ) Friend or relative
( ) Other (specify) ______________________________

(57)

2. What made you decide to utilize the social worker's services?

( ) Recommended by physician
( ) Recommended by friend or relative
( ) Recommended by hospital staff
( ) Self requested
( ) Can't remember
( ) Other (specify) ______________________________

(58)

3. In your opinion, how do you rate the helpfulness of social work services provided?

( ) Very helpful ( ) Somewhat helpful ( ) Not at all helpful

(59)

4. a. Would you use the service again?

( ) Yes ( ) No ( ) Maybe

(60)

b. Please explain your answer.

____

____

____

(61)

5. a. Would you recommend it to other patients?

( ) Yes ( ) No ( ) Maybe

(62)

b. Please explain your answer.

____

____

____

(63)

****

Thank you for taking the time to respond to this questionnaire. It will greatly enhance our ability to render quality service to Myasthenia Gravis patients.

(1-3)

F. ILLNESS RELATED VARIABLES
(Chart Annotated)

1. Clinical Classification ______________

2. Length of Time Since Diagnosis ______________

Department of Social Work Services
The Mount Sinai Medical Center

DRAFT OF

GUIDELINES FOR CHARGING FEES TO CERTAIN PATIENTS, CLIENTS AND THEIR FAMILIES

1. Introduction, Purpose and Content

These guidelines were developed in a series of meetings of concerned staff.* They provide preliminary direction for staff members who now charge and who plan to charge fees to some patients, clients and their families. They define:

- which patients/families should pay fees;
- what these fees should be
- how records should be kept, and
- how fees should be collected.

These preliminary guidelines will be revised and gain greater specificity as they are used, as data is collected and problems/issues reexamined.

2. Eligibility

This section defines who should be charged and those who should not be charged for social work services on a fee-for-service basis.

A. <u>Individuals requesting/receiving "non-mandated' services should be charged.</u>

There are several groups of individuals who seek social work services which are not "mandated", as described below, and not reimbursed. These individuals are eligible to receive these services when fees are expected as reimbursement for them. There are two main groups of such patients:

Group I - This group consists of patients and family members referred to or seeking social work services who have never been registered in the Mount Sinai system and who are not presently in-patients or attending any of the Ambulatory Care clinics.

Examples: -- Those private patients receiving medical care from an attending/consultant physician in his private office and referred by him for social work services; or their friends, families, relations, etc. We used to call these "courtesy" services.

---

* Andrew Weissman, Ruth Fizdale, Anne Crane, Susan Rubenstein, Penny Schwartz, Jane Silberman, Lucille Silverstein, Cindy Wagner and Ginny Walther

-- Friends and relatives of patients previously known to us, who themselves were not known to Mount Sinai Medical Center previously and who are requesting social work services.

Group II - This group consists of patients/families who request additional social work services after their mandated services have been completed.

Examples -- Patients who were known to us during hospitalization and who either continue on or return for help with another problem unrelated to the medical care originally received at Mount Sinai Medical Center.

-- Ditto former ambulatory care patients.

The guiding principle here is that the social work services rendered in conjunction with a medical service at Mount Sinai are completed; and that the individuals are seeking help with other and different problems.

B. Individuals receiving "mandated" services should not be charged

Most social work services provided to both in-patients and their families as well as those attending ambulatory care clinics are part of the package of medical care provided and funded (partially) by various reimbursement mechanisms paid directly to the Hospital, such as the per diem in-patient rate, out-patient Medicaid, self-pay rates and others. Patients receiving services under these auspices should not be charged a separate social work fee-for-service.

3. Determining Eligibility

Professional judgments are involved in determining when our mandated services are completed and when treatment is moving into a different phase, one distinct from the initial presenting problem. Since this is the beginning phase of the program, and we want to develop consistency in the implementation of these guidelines, the determination of whether and when fees should be charged will be made by the social work staff member together with the preceptor on a case-by-case basis.

4. Fee Scale

A. Basic Fee - The basic fee which will be charged for individual sessions is $35.00, a sum established by the Department.

B. Sliding Scale - When a patient/family cannot afford the full basic fee, a sum on a scale from $10.00 to $35.00 will be set by the social worker, with contract stating how many interviews each payment will cover.

C. No Fee Charges - No fee below $10.00 should be charged. Where this sum is not manageable for the patient/family, a no-fee-charged status will be established at the discretion of the worker and the preceptor.

D. Income Verification - Although the worker will have general discussion of income with the patient when the full basic fee cannot be paid, no procedure will be used to verify income and expenses.

E. Mount Sinai Employees - Mount Sinai employees who meet the guidelines for eligibility will be charged at the rate of their insurance reimbursement.

5. On-going Consultation

Ruth Fizdale and Andrew Weissman will be available for consultation to staff and preceptors around any issue in fee-charging: eligibility, establishing the fee, handling the fee as a treatment dynamic, etc.

6. Registration and Recordkeeping

A. Individuals already known to Mount Sinai Medical Center and the Department of Social Work Services

Those patients who have been known previously to and registered with Mount Sinai Medical Center and the Department, require no new unit number. Their cases should be reopened. Recording procedures will follow the usual guidelines, as the patient will have a medical chart and unit number.

B. Individuals never known to Mount Sinai Medical Center

When the individual has never been known to Mount Sinai Medical Center, or, when the family member of patients previously known to Mount Sinai Medical Center become active with us, the social worker will register the case.

C. Case Registration Procedure

a) The social worker will call the Statistical Unit for a unit number. Social Work has been assigned a series of unit numbers especially for this purpose.

b) This unit number should be used on the registration sheet.

c) Upon receipt of this registration, the statistical unit will return a case folder to the social worker.

d) The social worker will use the regular guidelines for chart recording in these cases and file these notations in the case record folder. The fee established with the patient/family should be part of the record.

e) At the case closing, the case record folder will be sent to the Statistical Unit along with the closing form(s).

7. <u>Fee Collection</u>

a) The fee will be collected by the social worker who will make out a receipt in triplicate on receipt forms available from our receptionists.

b) The social worker will give the original copy to the patient.

c) The social worker will give one copy of the receipt, along with the fee collected, to the Statistical Controller, including this information:

-- Patient's name
-- Unit number
-- Family member(s) name(s), if relevant
-- Amount of fee
-- Number of sessions covered by payment

d) The social worker will retain one copy for the case record.

8. <u>Conclusions</u>

Since we are carving out a structure, it will be useful to keep careful data; to share experiences and to revise this procedure as knowledge and principles become clearer.

PHYSICIANS COVERING LETTER

Date:

Dear :

Some years ago I established a social work service program for my Myasthenia Gravis patients. Since the project began in 1974, many patients and their families have consulted with this social worker and been helped with a broad range of social and emotional problems often accompanying this illness.

I am interested in learning whether this program should be further developed, and if so, how it can best meet the needs of patients like yourself in the coming months and years.

You are part of a group of patients who are being asked to give their opinions on this matter. Your name was drawn randomly from a list of Myasthenic patients in my practice. Whether you have used this service in the past or not, your guidance will be of great help.

Let me assure you of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that your name can be checked off from the mailing list when the questionnaire is returned. In order to protect your anonymity, no name will ever be placed on the questionnaire.

Please take a few moments, if you will, to complete the questionnaire and return it to me in the enclosed self-addressed envelope, as soon as possible.

You are under no constraints to participate in this study, of course. If you decide not to, it will in no way affect our relationship.

I look forward to hearing your comments and thank you for your assistance.

Sincerely yours,

Notice Mailed to Patients Regarding Questionniare Error

Please note that on the Questionnaire I mailed to you dated April 29, there was a typing error on Page 1 concerning the rating scale. Rating #4 should read: Very Unimportant instead of Very Important. The corrected scale is as follows:

1 = Very Important
2 = Somewhat Important
3 = Somewhat Unimportant
4 = Very Unimportant
5 = No Opinion

Once again I would appreciate your completing the questionnaire as it will allow us to improve our services to myasthenic patients.

(Physician's Signature)

TABLES

Description of Sample Population

(Questionnaire - Parts D and F)

Table I

AGE DISTRIBUTION

(N = 99)

AGE RANGE	NUMBER	PERCENTAGE
18 - 25	4	4%
26 - 35	23	24%
36 - 45	16	16%
46 - 55	11	11%
56 - 65	20	20%
66 - 75	16	16%
75 - 85	9	9%

MDN = 46 - 55

Table II

SEX DISTRIBUTION

(N = 99)

SEX	NUMBER	PERCENTAGE
Male	42	42
Female	57	58

Table III

ETHNIC DISTRIBUTION

(N = 100)

ETHNICITY	NUMBER	PERCENTAGE
White	93	93%
Black	4	4%
Puerto Rican	3	3%

Table IV

MARITAL STATUS DISTRIBUTION

(N = 100)

MARITAL STATUS	NUMBER	PERCENTAGE
Single	15	15%
Married	67	67%
Divorced	10	10%
Widowed	8	8%

Table V

CHILDREN LIVING AT HOME

(N = 95)

CHILD/NO CHILD	NUMBER	PERCENTAGE
None	56	59%
One	18	19%
Two	17	18%
Three or more	4	4%

Table VI

OCCUPATIONAL DISTRIBUTION

(N = 97)

OCCUPATION	NUMBER	PERCENTAGE
Homemaker	23	24%
Physician/Dentist	23	24%
Craftsman/Tradesman	21	21%
Retired	25	26%
Student	5	5%

Table VII
EDUCATIONAL DISTRIBUTION

(N = 100)

EDUCATION	NUMBER	PERCENTAGE
Elementary School	4	4%
Junior High School	3	3%
High School	35	35%
Trade/Vocational School	4	4%
1 - 2 Years College	15	15%
3 - 4 Years College	16	16%
More than 4 Years College	23	23%

Table VIII

CLINICAL CLASSIFICATION DISTRIBUTION

(N = 100)

CLINICAL CLASSIFICATION	NUMBER	PERCENTAGE
Stage I	6	6%
Stage IA	18	18%
Stage IIA	43	43%
Stage IIB	15	15%
Stage IV	4	4%
Stage of Remission	14	14%

Table IX

TIME SINCE DIAGNOSIS

(N = 100)

TIME SINCE DIAGNOSIS	NUMBER	PERCENTAGE
0 - 5 Years	33	33%
6 - 10 Years	16	16%
11 Years or More	51	51%

SERVICE COMPONENT PREFERENCES

Questionnaire (Part A)

Table X

INFORMATON ABOUT MEDICAL AIDS

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	65	66%
Unimportant	26	26%
No Opinion	8	8%

Table XI

INFORMATION ON BENEFITS

(N = 100)

RATING	NUMBER	PERCENTAGE
Important	85	85%
Unimportant	12	12%
No Opinion	3	3%

Table XII

ASSISTANCE WITH HOMECARE

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	56	57%
Unimportant	34	34%
No Opinion	9	9%

Table XIII

HELP WITH HOME MODIFICATIONS

(N = 100)

RATING	NUMBER	PERCENTAGE
Important	37	37%
Unimportant	48	48%
No Opinion	15	15%

Table XIV

ASSISTANCE WITH MEDICAL TREATMENT

(N = 100)

RATING	NUMBER	PERCENTAGE
Important	73	73%
Unimportant	20	20%
No Opinion	7	7%

Table XV

PROVIDE LETTERS

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	74	75%
Unimportant	21	21%
No Opinion	4	4%

Table XVI

GUIDANCE FOR EDUCATIONAL PROBLEMS

(N = 100)

RATING	NUMBER	PERCENTAGE
Important	54	54%
Unimportant	41	41%
No Opinion	5	5%

Table XVII

INFORMATION ON COMMUNITY RESOURCES

(N = 100)

RATING	NUMBER	PERCENTAGE
Important	81	81%
Unimportant	15	15%
No Opinion	4	4%

Table XVIII

HELP WITH MANAGEMENT OF ILLNESS

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	68	69%
Unimportant	25	25%
No Opinion	6	6%

Table XIX

HELP WITH MEDICAL PROBLEMS

(N = 98)

RATING	NUMBER	PERCENTAGE
Important	75	77%
Unimportant	19	19%
No Opinion	4	4%

Table XX

HELP WITH REACTIONS TO ILLNESS

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	83	84%
Unimportant	13	13%
No Opinion	3	3%

Table XXI

HELP WITH MOOD CHANGES

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	76	77%
Unimportant	19	19%
No Opinion	4	4%

Table XXII

HELP WITH SEXUAL FUNCTIONING

(N = 97)

RATING	NUMBER	PERCENTAGE
Important	49	50%
Unimportant	31	32%
No Opinion	17	18%

Table XXIII

HELP WITH SOCIAL/INTERPERSONAL PROBLEMS

(N = 98)

RATING	NUMBER	PERCENTAGE
Important	55	56%
Unimportant	38	39%
No Opinion	5	5%

Table XXIV

HELP WITH WORK RELATED PROBLEMS

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	60	61%
Unimportant	28	28%
No Opinion	11	11%

Table XXV

TREATMENT FOR EMOTIONAL PROBLEMS

(N = 98)

RATING	NUMBER	PERCENTAGE
Important	63	64%
Unimportant	27	27%
No Opinion	8	9%

Table XXVI

HELP WITH FAMILY PROBLEMS

(N = 98)

RATING	NUMBER	PERCENTAGE
Important	48	49%
Unimportant	33	33%
No Opinion	17	18%

Table XXVII

HELPING FAMILY MEMBERS COPE

(N = 99)

RATING	NUMBER	PERCENTAGE
Important	68	69%
Unimportant	26	26%
No Opinion	5	5%

SERVICE FEATURE PREFERENCES
Questionnaire (Part B)

Table XXVIII

ITEM	IMPORTANT	UNIMPORTANT	NO OPINION
Prompt Service	93%	7%	__%
Evening Hours	69%	27%	4%
24 Hour Coverage	79%	20%	1%
Home Visits	56%	40%	4%
Same Provider	84%	8%	8%
Cost of Service	84%	14%	2%
Flexible Pay Schedule	72%	26%	2%
Credit Card Acceptance	45%	42%	13%
Insurance	92%	5%	3%
Location	92%	7%	1%
Atmosphere	92%	7%	1%
Certified Provider	95%	3%	2%
M.D. Recommended	95%	5%	-%
Medical Center Affiliation	78%	18%	4%
Confidentiality	91%	6%	3%

PRODUCT FAMILARITY AND INTEREST

Questionnaire (Part C)

Table XXIX

FAMILIARITY WITH SOCIAL WORK SERVICES

(N = 99)

DEGREE OF FAMILIARITY	PERCENTAGE
Highly Familiar	17%
Somewhat Familiar	47%
No Familiarity	35%
No Answer	1%

Table XXX

INTENT TO UTILIZE

(N = 98)

UTILIZATION INTENT	PERCENTAGE
Likely to Utilize	56%
Unlikely to Utilize	44%

Table XXXI

REQUEST FOR BROCHURE

(N = 98)

RESPONSE	PERCENTAGE
Yes	87%
No	2%
Maybe	11%

Table XXXII

CURRENT EXPERIENCE WITH MENTAL HEALTH SERVICES

(N 99)

STATUS	PERCENTAGE
Yes	7%
No	93%

Table XXXIII

PRIOR EXPERIENCE WITH MENTAL HEALTH SERVICES

(N = 97)

STATUS	PERCENTAGE
Yes	37%
No	63%

SOCIAL SERVICE CONSUMERS - MYASTHENIA GRAVIS PROGRAM

SUB-GROUP ANALYSIS

Questionnaire (Part E)

Table XXXIV

REFERRAL SOURCE

(N = 18)

SOURCE	PERCENTAGE
Physician	83%
Hospital Staff	6%
Myasthenia Gravis Foundation	6%
Other	5%

Table XXXV

REASON FOR UTILIZING SERVICE

(N = 18)

REASON	PERCENTAGE
Physician Recommendation	72%
Friend/Relative Recommended	11%
Hospital Staff Recommended	6%
Other	11%

Table XXXVI

HELPFULNESS OF SERVICE

(N = 16)

RATING	PERCENTAGE
Very Helpful	63%
Somewhat Helpful	31%
Not at All Helpful	6%

Table XXXVII

USE OF SERVICE IN FUTURE

(N = 17)

RESPONSE	PERCENTAGE
Yes	59%
No	18%
Maybe	23%

Table XXXVIII

RECOMMENDING SERVICE TO OTHER PATIENTS

(N = 17)

RESPONSE	PERCENTAGE
Yes	88%
Maybe	12%
No	-%

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