

# **Marketing Strategy Overview**

**Chronic Disease Consumer Education Campaign  
Missouri Department of Health & Senior Services**

**MediaCross, Inc.  
St. Louis, Missouri Department of Health and Senior Services**

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## **Forming Goals for the Campaign**

As a metrics-driven media firm, MediaCross is committed to understanding the underlying goals, mission, and vision of the clients we serve. In this case, the Missouri Department of Health and Senior Services has asked MediaCross to help it with a chronic disease awareness campaign. This campaign takes into consideration how both those people who have chronic diseases and those at risk for chronic diseases can engage in positive behaviors -- specifically healthy eating, physical activity and medical screenings -- to manage or avoid chronic diseases' effect on their lives. We are to develop a message strategy to communicate to our target audience, and the campaign's overarching message strategy must be:

- \*Based on current evidence for success
- \*Relevant to the target audience
- \*Consistent and unifying
- \*Blame-free
- \*Simple and understandable, and
- \*Clearly descriptive of the desired actions we want people to take.

Our marketing strategy follows these goals and takes logical steps of action to arrive at a plan for communicating chronic disease awareness in Missouri. Logical steps of action start with defining the issue, then progress to: using scientific tools to narrow the audience, finding ways to segment the audience, delving into risk factors, and understanding the audience's core belief systems, attitudes and perceptions. Through these steps, we can demonstrate the advantages to scientific tools and prove the effectiveness of our methods.

### **Defining the Issue**

A principal part of any disease awareness campaign is to be able to clearly define and understand the disease at hand. It is of principal importance that the marketing agency, the sponsoring organization, and the audience all have the same consensus. If the message strategy is not based on a clear and shared understanding of the challenges, it would be difficult to express the issue to the audience. All campaign executions would need to be consistent, especially in a health campaign where different health issues have different significance to different people.

In this case, the issue is chronic disease. Research avenues have pointed to a definition that says a chronic disease is one that persists for a long time, usually 3 months or more, that generally cannot be prevented by vaccines, cured by medicines, and that does not usually "disappear." Several medical sources consider these diseases to be arthritis, cancer, cardiovascular disease, diabetes, epilepsy and seizures and obesity. Other sources include persistent oral health problems, strokes, etc. It is important to the message that all parties involved know this definition versus an "acute" illness that might exist for a more limited timeframe.

Our overarching theme revolves around all chronic diseases versus focusing on one specific disease per DHSS's request. In addition, other MediaCross health awareness campaigns for the state of Missouri have tended to show that a more general overarching message was more

effective than a specific focus. In this case, we are working on “chronic diseases” as a whole, rather than focusing on how to specifically prevent cancer or heart disease or some other disease. Eventually, in later phases of the campaign, there might be a focus on prevention of specific diseases. Either way, all creative executions, plans, and scientific tools would want to reflect agreement on chronic disease definitions.

### **Scientific Narrowing of the Audience**

In order to do a relevant marketing campaign, we need to determine who our “ideal” or “typical” audience member is. The best way to do that is to actually talk to people through measurable scientific tools. We would want to find a cross-section of people with different economic backgrounds, ethnicity, ages, genders, and home locations. These people would all have different viewpoints about their health situations as well as differences in what kind of information they pursue, how they pursue it, when they choose to pursue it, and where they go to get it. We expect to find a number of interesting correlations between our demographic characteristics and the actions mentioned in the questions. Our scientific method in this case could be thought of as a pyramid of sorts, where a large population is sampled, with more general questions, then it is narrowed to include a smaller population with more specific questions, and finally, the information is analyzed to reach a typical or ideal portrait. In this case, we chose three tools, including a literature review, a phone survey and focus group meetings. Our pyramid looks like this:

**Literature Review 50 sources**  
**Phone Survey 400 total respondents**  
**Focus Group 12 respondents per session**

A **literature review** has many advantages. One is the ability to look at multiple sources to inform marketing strategies. In this way, one can review journals, books and periodicals with scientific studies and previous campaigns regarding the issue. Sometimes, media channels are advised. Current communications theories can be readily explored, and those theories can inform the way the messages are sent. For example, in this case, Brian Hensel of the University of Missouri-Columbia, reviewed gain and loss frames in relation to the message delivery. This theory talks about the difference between communicating a message that shows people *what they have to gain* by engaging in the desired behaviors versus showing people *what they have to lose* by not engaging in the desired behaviors. Literature reviews, when possible, also give you an analysis of other media campaigns that have dealt with your particular issue. In this way, you can learn from the experiences of other campaigns and devote your resources accordingly. Our awareness campaign that covers multiple diseases offers a great advantage because it allowed us to look at campaigns that covered a specific disease when there were few, if any, that covered multiple diseases. Information in the literature review regarding prevalence of chronic disease also served as a good background for the delivery of messages.

In this case, this method also helps us understand who our target audience is and what kind of knowledge, beliefs and social norms are typical for that audience. We can take what we find in a literature review regarding people’s patterns of behavior, belief systems and knowledge and use it to inform phone survey questions, focus group questions and creative. This review helps us

customize our approaches to different subgroups within the target audience. We specifically learned many things, including the advantages of using role models for behavior messages, reasons to do messages that increase self-efficacy, reasons for focusing on health behavior messages that show costs in terms of health and quality of life of no early detection, that important others are a key part of the screening messages, as well as supportive evidence of messages that show the benefits of small steps over time.

**Phone surveys** have a number of advantages. They allow you to reach a wide audience through random dialing and are quantitatively measurable. A wide audience in this case gives us a good representation of Missourians 45 years of age and older who are at risk for chronic diseases or who have been diagnosed with chronic diseases. By getting a representative population, we can extrapolate data and apply it to the typical or ideal person. Randomness in the selection process for the phone survey assists us in ensuring that there are no factors that could skew the results and make them not “generalizable” to the population of Missourians. Phone surveys also give MediaCross and its partners the opportunity to create a customized script that covers the issues we most want to know about the residents. The surveys can reach people in different Missouri counties and areas outside of our “home base” in St. Louis. For a disease awareness campaign, the kind of phone survey we conducted can help us understand prevalence in our state. It’s critical to understand prevalence of the disease in our state and behaviors in our state because they can be influenced by both geography and culture. Perhaps Missourians have more of an “indoor” culture than those in Utah who live close to the mountains. Perhaps New Yorkers participate in physical activity more because they have a “walking” culture due to their public transportation system versus St. Louis and its “car” culture with little public transportation. There are a number of studies done by government departments and foundations throughout the United States, and while these are useful to understand the issue-at-large, we cannot generalize them to the Missouri population.

This phone survey allows us to pinpoint issues of particular importance to Missourians and choose the best media channels for the campaign. Surveys conducted and evaluated by professional research institutions also have the advantage of empirical data sets, and increased accuracy, and can be applied across multiple avenues.

**Focus groups** help an agency understand more specific ideas relating to what was learned in the phone surveys and literature reviews. In this way, one can talk face-to-face with a smaller number of interviewees. To facilitate lively discussion and lend focus to the session, usually these run around 8 to 10 people. One can probe more qualitatively in this process. One can ask questions about opinions, tastes and behaviors that one might not be able to ask in a more formal session. An informal session allows people to have a string of thoughts and engage in a thought process that can be enhanced by the ideas of others. The energy this can create in a room can often greatly influence messages. One can test messages, themelines, images and concepts. One can ask questions about media, can ask questions about people’s perceptions and decision-making processes. As well, one can ask people questions about what issues are most important. Sometimes, debates over a concept or previously-held view that the sponsoring organization or marketing agency came up with can yield a new perspective or media direction. This is an organic process that can give more specificity and clarity to the project’s execution.

We can test different message executions using what we learned in the literature reviews and our early creative analysis.

In this case of chronic disease awareness, we were given a low-income focus for our population. So, MediaCross looked at places where low-income people reside and also where we could get a representative population in terms of geography. We chose a mix of rural and urban areas represented by St. Louis City; Kansas City; Greene County; New Madrid, Pemiscot or Dunklin counties; and Adair or Macon counties. These counties are representative of different geographic areas of the state, and epidemiological data shows that they are each areas with high incidence of a variety of chronic diseases.

### **Segmenting our Audience**

Gaining knowledge of prevalence of the disease in the United States and the Missouri population was also an important part of our knowledge base. By knowing the age groups affected and how this issue has become important among state residents, we can understand the ways that we might be able to communicate the actual impact and urgency of the issue. Research shows us that people are more likely to pay attention to issues that have been demonstrated as far-reaching and highly relevant to their lives. In this case, the fact that 70% of Americans die from a chronic disease is an alarming number. Once we understand just how many people are affected, we want to look at demographic baselines for age groups, race groups and gender.

These “baselines” help us form a good hypothesis for how we should specifically define our target audience. Prior to the use of scientific tools, we studied a multitude of credible, and varied, reports from the Department of Health and Senior Services, the National Institute for Health, the AARP, the CDC, local universities, chronic disease coalitions, the Missouri Foundation for Health, the Urban Institute, the Kaiser Foundation. These national and state sources, including private and independent think tanks and research centers, help us get an understanding of current chronic disease research that, at its most advantageous times, contains information that has been gained for varied goals and agendas, and has information that has been collected over a long period of time. These varied views inform message strategies because they consider diverse groups of people and independent research methods.

Our first baseline was age groups. The studies revealed that our audience would best cover those people ages 46 to 64, as a segmented audience in three groups, and then those people ages 65 and older. The reasons for this were that, in a prevention-focused campaign, it makes sense to go with the population of adults that are most at risk. We found that adults aged 65 and over make up a smaller percentage of the country’s total population, and that starting at the age of 65, most people are already living with a chronic disease. In addition, the people who are doing caregiving are family members and are more likely to be adults between the ages of 18-65. These national statistics suggest that prevention behaviors might be more prevalent in, and messages more salient to, slightly younger populations of Missourians aware of the effects of chronic disease based on observation of their family members. Segmenting that audience for different message strategies would be advantageous. Other research concluded that older adults ages 50 and older have transition periods in their lives, including moving from employment to retirement, that

affect their screening and prevention behaviors. We reasonably decided, then, that our scientific methods should capture those audiences and consider their changing beliefs and attitudes.

With regard to racial background, ethnic groups, and gender, we have been keeping in mind a mandated demographic picture that includes mostly Caucasian stakeholders. Our preliminary research suggests that while Caucasians make up a relatively high proportion of the Missouri residential population, the people most at risk for chronic disease are black and Hispanic. One source said that African Americans are much more likely to die of chronic disease than people of other racial backgrounds. A Kansas City coalition found that “on average, people of color have a life expectancy of 11 years less than whites.” We also found through the United States Census and other foundation resources a statistic that says 17% of all Missourians are in the high risk ethnic populations of black, Hispanic or other. These findings support a consideration of the attitudes, perceptions and portrayals of a diverse group of people throughout the project. Finally, we noticed that the Department of Health and Senior Services focuses on women ages 40-64 in its WISEWOMAN program for prevention of disease. This and other sources seem to suggest that gender does play a role in pursuit of prevention behaviors, attitudes toward physical activity and screening frequency. We took the baselines that revolved around the United States population and then honed in on the Missouri population.

The result of these studies was that the core committee decided to look at people 46 years of age and older, segmented by 45-54, 55-64, 65+. We anticipate early that the messages would probably target an audience that is non-gender specific and diverse.

### **Delving into Risk Factors**

Also helpful in contributing to target audience understanding is knowing what kinds of risk factors are facing the residents of the state. By reviewing multiple sources, including the Behavioral Risk Factor Surveillance System (BRFSS) and other government health resources, we can see what actions people are taking and what they are doing that influences risk for chronic disease. Missourians had a higher percentage than the nation as far as presence of heart disease risk factors in 2003. These were in the categories of ever been told have high blood pressure, told they had high cholesterol, were current smokers, had no leisure time physical activity and did not eat five servings of fruits and vegetables per day. In light of these present risk factors, we can discuss mechanisms for change to portray in our messages and creative. As well, we know we would want to probe further to understand why people are not engaging in these desired behaviors.

When we do put into action our messages, we want to consider accuracy and identity. We want to get correct information that does not improperly communicate risks and be careful of our statistics. In addition, if our target audience doesn't feel like we are “talking with” them, and do not identify with the characters we introduce, then the message has no impact. Therefore, we would want to focus on the important questions of “why.” As part of our firm's goal-oriented policies, we work toward impactful, relevant, actionable messages that make a difference in the lives of the people we are trying to reach. The goal is to ensure that people are actually going to do the desired actions of: engaging in screening behaviors, eating healthy and pursuing physical activity.

## **Understanding Information and Influence**

Is “the medium the message” where health behaviors are concerned? We want to know what kind of information and influence media channels and other people have on our audiences. Gauging how much people trust television, the Internet, radio, brochures, fact sheets, magazines and other vehicles helps us understand their potential impact. For some audiences, the degree to which they trust certain people has a lot to do with a world view shaped over many years by their changing family/living situations, their access to education and if they have exposure to media at all. In some instances, factors such as income, education and geographic home location can show drastic differences in media exposure.

Perceptions and core belief systems influence people’s active or inactive pursuit of information through media channels. We evaluate:

- \*How does our target audience decide where to get information about health and chronic disease?
- \*Whom do they trust to tell them about health information and chronic disease?
- \*What do their information sources tell them about health and chronic disease?
- \*Are these media reaching these audiences with the intended messages?
- \*Do people care about accessing this type of information, or do we need to spend more time focusing on accessibility?
- \*Does this new knowledge cause people to act?

These questions all help in gauging what media channels to pursue and what marketing partnerships we can form to gain frequent message exposure. We call our measurements “impressions,” which means the number of people who could be exposed to a message over a specified period of time. The campaign goal is to reach as many Missourians, 45 years of age and older, as possible. We ask where people are getting their information because we want to be visible to this audience. Of course, a highly visited venue or frequently read bulletin board would reach more Missourians.

As well, the delivery of the message plays a role in people internalizing messages we create. We want our audience to take our messages to heart, to act and to apply them to their lives. A delivery person whom our audience does not trust could, in fact, cause the opposite reaction that we intended. So, we ask our survey respondents if they trust their family members, doctors, friends, local celebrities, politicians, public figures, local government sources and some other sources for health information. As well, the literature review and other studies show that the vocalization of “significant others” can play a great role in helping people engage in prevention behaviors such as screening. We study that as well through our scientific tools.

## **Understanding Core Belief Systems, Attitudes and Perceptions**

To get someone to undertake desired actions, we next need to pinpoint how our audience will perceive the messages we send. To that end, we consider how the messages can appeal to

specific behaviors, how they can motivate our audience and how we can tailor the messages to fit into the framework of world views and core belief systems. We want in this sense as well to encourage people to apply our messages to their lives.

Throughout history, education has shown to shape the world views of people and lead them to action. In this case, the Missouri Department of Health and Senior Services has given MediaCross the task of educating Missourians about chronic disease prevention and management. Core belief systems, attitudes and perceptions need to be tested. When considering the core beliefs of our audience and their ability to internalize our messages are:

- \*What are my feelings about life and death?
- \*What do I believe about my personal health?
- \*Do I believe I have control over my personal health?
- \*Should I medicate myself, and how does that affect my life?
- \*Do my actions matter where it concerns my health and my destiny?
- \*Am I acting on my knowledge of health issues?
- \*Can I change my lifestyle?
- \*If I change my lifestyle, what does that mean for my destiny?

Where chronic disease is concerned, an education regarding the ways that chronic disease could be avoided or well-managed might make a difference if it fits into the beliefs people have about how they can actually *live with* the diseases versus *dying from* the diseases. And, of course, these issues of life and death have always resonated as fundamental to the human experience. Our scientific instruments, including phone survey, focus groups, literature reviews and other research, seek to both validate and openly debate the views we think Missourians hold and find out what in particular can inspire action. We have two groups of people with feelings to think about, including “people at risk for chronic disease” and “people who already have chronic disease.”

First, we consider “people at risk for chronic disease.” We want to measure what prevention behaviors they currently engage in, including how frequently they participate in physical activity, how they view their current health status, what their eating habits consist of, sources they trust for health information, how often they visit the doctor and why they would visit and what kinds of media they trust and access. It is also important to find out what prevention behaviors our audience would engage in *if* armed with the information and knowledge they needed to maintain good health in regard to managing/preventing chronic disease. This is one of the reasons we ask the questions about perceptions, eating habits, screening behavior and access, healthcare access/coverage, healthcare pursuit, barriers to behavior and where they might review or learn health information. We wonder for both groups if they would be likely to engage in these promoted behaviors after the campaign. If executed successfully, the campaign uses all of these ideas about life, death and health to relate on a personal level to the target audience.

Secondly, we consider “people who already have chronic disease.” Many of the same issues we explore above concerning core beliefs about life, health and death, as well as message delivery and credibility of information sources, apply to this population. The difference for this group would revolve more around the actions taken after diagnosis. We want to know where they are being diagnosed, whether or not they are acting on the information of a diagnosis, their current

screening behaviors as a result of the diagnosis, their disease management, their trust in sources for health information, their access to healthcare and their caregiving situations where applicable. Armed with this specific understanding of people living with the disease, we can determine exactly how to reach the audience, especially if we know where they are spending their time. Our preliminary research suggests that people over age 65 have at least one chronic disease. It goes without saying that people in this population may or may not be living in their homes and may or may not be able to leave their places of residence as a result of their health conditions and/or chronic diseases. At that point, we would need to review our message content and placement, while looking for entreaties that might inappropriately advocate an outside pursuit of knowledge.

Healthcare access also takes into consideration whether or not people are pursuing medical treatment and pursuing screenings after they have been diagnosed with a chronic disease. People who already have chronic disease are thinking about whether or not they *can* live with the disease, as well as *how* they can live with it. Our scientific tools attempt to tease out who exactly lives with the disease and what kinds of portrayals will best reach the audience. Where did our audience go when they were worried about chronic disease? How did they view their diagnosis in light of their life/death/health views? What will they do about the diagnosis? Can the person do anything about the chronic disease? Where will they go for information? All of these questions point to important matters in the lives and habits of our constituents over a recent period of time.

As important as the two audiences are the time frames in which they view their chronic disease onsets, health habits, and behaviors. We make all efforts to try and prove patterns of behavior. It certainly makes sense to specify the behavior's actual frequency in units, such as years, and then ask if someone currently would be engaging in a certain behavior. These qualifications can show us whether or not these screening, management and prevention behaviors happened earlier in their lives or later, and whether their performance of these activities continues now. Perhaps we will find that people are not changing their attitudes about their own health and their perceptions of control.

## **Looking Forward and Achieving Goals**

As we look forward to the possible execution of the campaign, we want to be sure that we are meeting the goals set forth by the Department of Health and Senior Services. We want to ensure that our development is *based on current evidence for success*. By reviewing available literature on the prevalence of chronic disease, by reading about other disease awareness campaigns, and by evaluating previous MediaCross health awareness campaigns, we were able to think about what would make this campaign successful. To keep our eyes on *relevance to the target audience*, we measure the audiences' situations, feelings, belief systems and actual live reaction to differentiated questions and creative through scientific tools. In addition, we ponder how our campaign could be *consistent and unifying, blame-free*. A consistent message comes from reaching a consensus about the definition of the disease, from understanding the varied and similar ways people are dealing with and finding out about the disease, and then bringing together all of these fundamental ideas in an actionable package. Only when we truly, clearly get at the motivations of our audience and their barriers to health behaviors can we find something unifying and powerful.

*A simple and understandable* campaign message can be achieved by not only understanding the definition, but by complicating our original task to some degree. It's simply not enough to only consider one viewpoint about the diseases' prevalence, to make assumptions about how people are dealing with the disease, to consider that people at all demographic levels have the same belief systems or to just work out of our own experiences or beliefs about chronic disease. Exploring many resources, and honing in on the resources that other people explore, is critical to simplifying the message. Reviewing all of these things helps us observe major patterns in behavior and motivation that we can use to reach the majority of Missourians. And, in order to *clearly describe the action desired and link with an overarching theme*, we had to consider how our audience's patterns might be segmented into different groups through our research, survey and literature reviews, first through age baselines and then through demographic characteristics. Perhaps we will find through our scientific tools that further segmentation is needed to reach different genders, different income groups, or different home locations. Also of a matter of importance was to know the actions we desired, which were: regular screening or visits to the doctor, healthy eating and regular physical activity.

We conclude here, for purposes of summary, and using our available resources, including early scientific tools like a literature review and research, that these desired actions would be more likely communicated with messages of self-efficacy. We expect to find in our tools that people are more likely to engage in prevention behavior if they feel empowered to do so, if they feel that barriers to the prevention behaviors are going to be lifted or lightened, and if they understand where to get the tools to do so. We expect to find differences in access to information and trust of information sources in different demographic groups. We expect to find differing opinions about the way that disease enters and continues in the lives of Missourians. We expect to hear that people will act on messages from qualified professionals or the people closest to them. And, we hypothesize that people will tell us that their poor health choices might continue even in the face of a well-executed campaign.

We hope that these sorts of revelations would not discourage concerted efforts to make Missourians healthier, to help our population manage their lives when faced with a reality that might include living uncomfortably as they age. The effects of this chronic disease campaign should have many positive outcomes throughout the state, including:

- \*arming the audience with an awareness of their risk for chronic disease
- \*giving people the tools to manage/prevent the onset of chronic disease
- \*making people aware of their own roles in taking responsibility for their health
- \*inspiring people to adopt behaviors to preserve their own health
- \*motivating people to encourage others to adopt behaviors preserving health
- \*increasing the number of people making screening behaviors a priority
- \*helping policymakers understand crucial healthcare information access issues
- \*serving as a model for other government-sponsored disease awareness campaigns at the local and state level.

Ideally, we would love for our efforts to put the power and responsibility of healthy behavior back into the hands of Missourians. Inspired by their new knowledge, eventually we would hope

to see our 45+ population with a lower incidence of chronic disease as they live longer, healthier lives.