Reaching the patients the system misses.

An integrated marketing plan for launching a satellite clinic in rural Sullivan County, New York.

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SECTION 01

Executive Summary

An affluent hospital system opens its first clinic in a county its peers have left behind.

This plan launches a satellite clinic in underserved rural Sullivan County, focused on preventive care and chronic disease management. It targets a specific, hard-to-reach population, applies Social Cognitive Theory to drive behavior change, and aims to earn trust before asking for engagement. The objective is measurable improvement in access and outcomes across the region.

SECTION 02 — SITUATION ANALYSIS

A county under strain.

Sullivan County carries a high burden of chronic disease and substance use against a thin supply of providers. The need is clear in the data; the barrier is access. Source: Garnet Health Community Health Needs Assessment, 2022.

33%

ADULTS WITH HIGH BLOOD PRESSURE

45.9

OPIOID OVERDOSE DEATHS PER 100,000

2,898:1

RESIDENTS PER PRIMARY CARE PHYSICIAN, VS. 1,180:1 STATEWIDE

34%

LIVE IN A HEALTH PROFESSIONAL SHORTAGE AREA

SECTION 02 — SITUATION ANALYSIS

The barriers beneath the numbers.

Health outcomes in the county are shaped less by clinical factors than by social ones.

01	**Economic hardship**	Poverty, unemployment, and food insecurity all run above state averages.
02	**Low educational attainment**	An 82% graduation rate, the lowest in the Mid-Hudson Region, depresses health literacy.
03	**Cultural and language gaps**	A growing Hispanic/Latino (17.4%) and Black (10.2%) population, with 15.8% speaking a primary language other than English.
04	**Geographic isolation**	Rural distance compounds provider shortages and makes transportation a barrier to every visit.

SECTION 03 — TARGET MARKET

Defining the Bystanders.

A blend of Segment 4 (Bloem-Stalpers) and the Bystanders (Deloitte). The patients most health systems never reach.

01	**Older, lower-income women**	Predominantly older women with limited educational attainment and the lowest household income.
02	**Facing real barriers**	Transportation, cost, low health literacy, and little perceived control over their own health.
03	**Higher clinical risk**	A higher prevalence of chronic disease and risk factors: obesity, smoking, and substance use.
04	**Disengaged from care**	Complacent, tech-averse, resistant to change, and not engaged in prevention or wellness.

SECTION 03 — TARGET MARKET

Why this segment.

The Bystanders are not just reachable. They are the segment where a new clinic can do the most good.

01	**Highest need**	The segment carries the county's heaviest load of preventable chronic disease and risk.
02	**Most underserved**	Transportation gaps, cost, and provider shortages keep them out of care entirely.
03	**Room to build trust**	Past negative experiences left them wary. A clinic that shows up well can earn lasting loyalty.
04	**Measurable impact**	Concentrated need means interventions here move the county's outcomes the most.

SECTION 04 — GOALS & OBJECTIVES

What success looks like.

The campaign goal is to improve health outcomes by increasing access to preventive care and chronic disease management. Three measurable objectives track progress.

+20%

CLINIC VISITS AND PROGRAM ENROLLMENT, YEAR 1

90%

PATIENT SATISFACTION RATING, WITH 25% REFERRALS FROM CURRENT PATIENTS

−10%

OBESITY AND SMOKING PREVALENCE IN THE TARGET SEGMENT, WITHIN TWO YEARS

2yr

HORIZON FOR THE RISK-REDUCTION TARGET

SECTION 05 — BEHAVIOR CHANGE STRATEGY

Grounded in Social Cognitive Theory.

Three constructs structure how the clinic moves patients toward healthier behavior.

01 — SELF-EFFICACY

Build the belief that patients can manage their own health.

Skills-training programs and peer support groups help patients manage chronic conditions and navigate the system.

02 — OBSERVATIONAL LEARNING

Show progress through people the community trusts.

Patient success stories and community health workers model the benefit of managing health well.

03 — REINFORCEMENT

Reward the behaviors that lead to better outcomes.

Incentives for attending preventive appointments and joining disease management programs: gift cards, discounts, recognition.

THE STRATEGIC INSIGHT

Engagement *follows trust.*

This segment has been let down by the system before. Asking them to enroll, attend, or change behavior comes second. Earning their trust comes first.

SECTION 06 — MARKETING MIX

Built around access.

Every element of the mix is designed to remove a barrier this segment actually faces.

PRODUCT

Primary and specialty care built for the rural population: telemedicine, mobile health, chronic disease management, and substance use treatment.

PRICE

Sliding-scale fees by income, payment assistance, and contracts with Medicaid and Medicare Advantage plans.

PLACE

A central, accessible location with extended and weekend hours, transportation assistance, and on-site pharmacy, labs, and imaging.

PROMOTION

Community outreach, faith-based partnerships, culturally relevant advertising, and provider-patient engagement tools.

SECTION 06 — POSITIONING & BRANDING

A trusted partner, not a provider.

POSITIONING

A trusted, accessible, culturally competent healthcare partner invested in the wellbeing of the Sullivan County community. It understands the county's needs, prioritizes access, and commits to long-term relationships over one-time visits.

BRANDING

An identity built on three commitments: patient-centered care that tailors plans to each person, advanced expertise in rural and chronic conditions, and the visible use of technology to widen access.

SECTION 07 — PROMOTIONAL CHANNELS

Meeting patients where they are.

Channels weighted toward trusted, in-person, local touchpoints. This is not a digital-first audience.

01	**Community outreach**	Health fairs, farmers markets, festivals, and collaborations with schools and senior centers.
02	**Direct mail and print**	Brochures, flyers, and postcards, plus advertising placed in trusted local media.
03	**Digital and public relations**	A clear website and social presence, optimized local listings, and earned media around sponsored events.
04	**Internal marketing**	A patient referral program, personalized interactions, and satisfaction surveys that close the loop.

SECTION 08 — IMPLEMENTATION PLAN

Sequencing the launch.

Four phases move the clinic from research to a community-embedded practice.

01	**Assess and define**	Run a community health needs assessment and focus groups to finalize services and messaging.
02	**Develop materials**	Produce culturally and linguistically appropriate marketing and clinic materials.
03	**Educate and engage**	Launch patient education and engagement programs that support behavior change.
04	**Build partnerships**	Establish relationships with community partners for sustained outreach and referrals.

SECTION 09 — CAMPAIGN EVALUATION

Measured at three levels.

Process, outcome, and impact measures track the campaign from activity to health result.

01 — PROCESS

Did we reach people?

Marketing distribution and reach, digital and social engagement, media impressions, and community event attendance.

02 — OUTCOME

Did they act?

New patients and referrals, program enrollments, patient satisfaction scores, and financial performance.

03 — IMPACT

Did health improve?

Changes in obesity and smoking prevalence, healthcare utilization, and patient satisfaction across the segment.

THANK YOU

Access first.
Then outcomes follow.

Earn trust, remove the barriers to care, and reach the patients the system overlooks.
That is how a satellite clinic changes the health of a county.

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