Crowning Achievement of a Species
History’s Most Successful Dinosaur—At a Museum Near You

*Tyrannosaurus Rex* (“Sue”)
circa 70-65 million years ago
North America

“Sue”
circa 2011
Field Museum, Chicago, Illinois

Evolving Ahead of the Herd

Stealing a Page from Apple’s Playbook

Constantly Adapting to Redefine Success

Identifying the Next Step

“The cure for Apple is not cost-cutting. The cure for Apple is to innovate its way out of its current predicament.”

Steve Jobs
Apple, Inc.1


The New Global Epidemic
Modern Lifestyles Taking a Serious Toll

Chronic Disease the Top Public Health Concern

63%
Percent of deaths worldwide due to non-communicable diseases

7 of 10
Deaths in the U.S. attributed to chronic conditions

122 M
Adults in U.S. with at least one chronic condition; almost one of every two U.S. adults

World Health Organization Identifies Key Risk Factors

Lifestyle Factors
• Tobacco use
• Physical inactivity
• Unhealthy diet

Limited Health Care Access
• No preventative care
• Cost-effective interventions inaccessible


1) Includes CV disease, cancer, diabetes, chronic respiratory diseases.
If We Were Building from SCRATCH

Assembling the Ideal Health Care Solution
If We Were Building from Scratch…
Assembling the Ideal Health Care Solution

**Health**
- Care management appropriately matched to individual patient, population need
- Oriented toward patient-centered goals that will drive clinical metric improvement

**Caregivers**
- Team available to patient for access, education, decision support
- Accessible when, where patient needs care

**Sites of Care**
- Multidisciplinary team works together to maintain unified care plan across patient needs
- Data transparency, sharing to ensure streamlined patient care

**Care management**
- Dashboard aligned to key cost, quality goals for improving population health
- Information available across the continuum to track utilization

Source: Health Care Advisory Board interviews and analysis.
Overwhelmingly, Patients Do Not Follow Their Care Plan

Patients Who Strongly Agree They Follow Treatment Regimens Carefully

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>66%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>59%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>50%</td>
</tr>
<tr>
<td>Depression</td>
<td>38%</td>
</tr>
<tr>
<td>Asthma</td>
<td>37%</td>
</tr>
</tbody>
</table>

1 in 2 Adults with one or more chronic conditions

50% Chronic condition patients with poor medication adherence

A1 Link these to the BUILD areas of intervention
Do any of the BUILD ideas go to following treatment regimens?
Author, 11/13/2015
The Steep Price of Disengagement

Solutions Require Integrating Care Model Redesign and Engagement

21%
Costs for asthmatic patients with low activation versus highly activated patients

1.5M
ED visits due to COPD exacerbations

$100-300B
Cost of low adherence to medication

Patient Engagement Flashpoints

- Avoidable ED Utilization
  - Problems with medications
  - Skipped or forgot care plan steps

- Missed Follow-Up Steps
  - Underestimated need to meet with care team
  - Deprioritized visits on to-do list

- Missed Primary Care Utilization
  - Could not afford visit
  - Location was inconvenient

If BUILD could address engagement on
Author, 11/13/2015
Reengineering our Assets with the Ideal in Mind

Setting Our Sights on a (Gradual) Evolution

Becoming the New Breed Health System

Developing a New Genetic Code

Scaling for efficiency, clinical and continuum reach

Preparing for full data transparency

Redeploying physician workforce

Elevating leadership role for leveraging information systems

Extending to meet community needs

Elevating clinical and non-clinical care team

Matching footprint to population need

Proactively utilizing patient data

Extending Our Reach

Adaptation to New Environment

Physical Footprint

Clinical Workforce

Information Asset

Time

Source: Health Care Advisory Board interviews and analysis.
Revising the Playbook for 2020

Anticipating Fundamental Changes in Our Approach

<table>
<thead>
<tr>
<th>Redefining the Footprint</th>
<th>Playbook for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Secure scale for operational efficiency, contract negotiation</td>
</tr>
<tr>
<td></td>
<td>Ensure seamless transfer from acute care to post-acute, primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Playbook for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leverage partnerships as assets to ensure full continuum reach, bring best-in-class care local</td>
</tr>
<tr>
<td>View scale through lens of clinical expertise, continuum reach</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leveraging the Information Asset</th>
<th>Playbook for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize Meaningful Use requirements to earn bonus, avoid penalty</td>
<td></td>
</tr>
<tr>
<td>Begin to forge connections with other providers working with the same patient population</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Playbook for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize enterprise network to inform care pathway development, conduct analytics to determine population need</td>
</tr>
<tr>
<td>Expand reach into patient home with continuous monitoring, proactive support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transforming the Clinical Workforce</th>
<th>Playbook for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure profitable specialist alignment</td>
<td></td>
</tr>
<tr>
<td>Engage and secure PCP access and referral chains</td>
<td></td>
</tr>
<tr>
<td>Shift PCPs to medical home practice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Playbook for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance local and virtual workforce</td>
</tr>
<tr>
<td>Utilize PCP as leader of care team</td>
</tr>
<tr>
<td>Engage non-clinical peers to maximize patient outreach and support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Realizing Our New Reach</th>
<th>Playbook for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin to identify populations—such as employees—to pilot accountable care opportunities</td>
<td></td>
</tr>
<tr>
<td>Pursue payer or employer pilots to test new care delivery models</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Playbook for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilize community leaders to improve overall neighborhood health and wellness</td>
</tr>
<tr>
<td>Partner to connect with, not re-create, highest-value community resources</td>
</tr>
</tbody>
</table>
From Goal Setting to Graduation

Design the Process for Self-Management Success

- **Recruit to Care Management**
- **Equip Patients to Change Behaviors**
- **Support Ongoing Self-Management**

**Level of Care Management Effort**

**Goal Setting**

**Follow-Up Visits, Home**

**Home**

**Care Management Team**

**Caregivers, Community**

**Begin to step down care management**

**Primary Care Office**

**Follow-Up Visits, Home**

**Home**

**Care Management Team**

**Caregivers, Community**

**Begin to step down care management**

**Time**

**Location**

**Owner**

**Usage of Technology**

- **Primary Care Office**
- **Follow-Up Visits, Home**
- **Home**
- **Care Management Team**
- **Caregivers, Community**
- **Follow-Up Visits, Home**
- **Home**
- **Care Management Team**
- **Caregivers, Community**
- **Low**
- **Medium**
- **High**

Source: Health Care Advisory Board interviews and analysis.
# The Shared Accountability Care Model

## Keeping Patients Activated, In-Network, and Brand Loyal

1. **Recruit to Care Management**
   1. Hardwire screenings to identify comorbid health conditions
   2. Link care plan to motivating goals
   3. Redesign in-office education prioritizing near-term management
   4. Schedule immediate follow-up steps as part of the primary care visit

2. ** Equip Patients to Change Behaviors**
   5. Define process to onboard patients
   6. Establish graduation milestone at the beginning
   7. Focus education on real-world management
   8. Deploy a flexible care team to support shared care goals
   9. Implement short-term support systems to reinforce new routines

3. **Graduate to Self-Management**
   10. Create easy communication channels for patients
   11. Integrate ongoing management tools
   12. Equip caregivers to encourage patient self-management
   13. Partner around benefit design to support long-term health promotion
   14. Convene community network around shared health goals

Source: Health Care Advisory Board interviews and analysis.
Innovation Focused on Community Health

Partner with Organizations to Align Resources for Ongoing Management

Minnesota: BlueCross BlueShield offers partial or full reimbursement of health club membership costs

Flagstaff, AZ: North Country Healthcare, Inc.’s Health Start. Offers free educational program to pregnant women

Honolulu, HI: KVIBE. Youth bicycle education program provides safe environment for fitness

New York, NY: Fruit and Vegetable Prescription Program. Physician prescribes Health Bucks redeemable at farmers markets

Wallingford, CT: Healthy CT. Insurance offers 10% off Fresh Nation Purchases

Philadelphia, PA: Philly Food Bucks. SNAP recipients receive $2 coupons for Farmer’s Markets for every $5 spent using SNAP

Austin, TX: FVRx. Clinic issues pregnant women prescriptions for fresh produce and cooking classes

Source: Health Care Advisory Board interviews and analysis.
Uncertain Times, Unprecedented Allies

Novel Partnership Meets Strategic Needs for Both Parties

**Duke University Health System**
- Guidance in clinical service development
- Support for enhancing quality systems
- Access to highly specialized medical services to meet community needs

**LifePoint Hospitals**
- Range of operational, financial resources
- Access to capital for ongoing investments in new technologies, facility renovations
- Community focused

**Duke-LifePoint Joint Venture**
Combines outstanding clinical leadership and resources with strong financial and operational expertise to help community hospitals prosper, offer communities better care

**Case in Brief: Duke-LifePoint Joint Venture (DLP)**
- Joint venture between Duke University Health System, a multi-hospital system including an academic medical center and two community hospitals, headquartered in Raleigh-Durham, North Carolina, and LifePoint, a 52-hospital system with locations in 17 states, headquartered in Tennessee
- Combined strengths offer independent hospitals option that meets clinical, operational, capital needs

Not Your Typical Assets

Collaborating with Local Leaders, Investing in Community Resources

**Community Leadership Collaborative**

- Consists of 25 community leaders
- Concerns over potential turf battles assuaged as group centered on common goals, concerns
- Originally met monthly, now quarterly

**Plan for Delivery of Efficient Care**

- Increased utilization of high-value preventive, primary care services
- Streamlined community offerings, less duplication, especially critical with declining funding, economic downturn
- Identified understanding culture of poverty, relationship to ED utilization as priorities
- Established common language and nomenclature for continued group momentum, collaboration, and innovation

Competing on Patient Engagement

Phases of Health System Value Creation

- **New Performance Baseline**

  - **Elevating Engagement in the Episode of Care**
    - Focus on individual patients and individual episodes
    - Fixing problems in today’s system around care delivery and coordination to ensure a complete, high-quality episode of care

  - **Driving Engagement in Ongoing Management**
    - Focus on targeted groups such as high-risk patients or chronic condition management
    - Building system for proactive management, low-acuity access and ongoing patient self-management

  - **Transforming Community Health through Engagement**
    - Focus on opportunities to impact population and community health
    - Identifying opportunities to spur community groups in health activities and drive broader population health

- **Adding Value through Population Health Improvement**
Good for the Community, Good for the Organization

Shifts in Utilization Patterns Generate Financial Returns

$167,000
Forecasted savings for Q1 2011 if all low-acuity patients seen in primary care instead of ED

$1.2 M
Increase in revenue for medical home services from 2009 to 2010

Number of Visits to Family Health Center, Emergency Department

<table>
<thead>
<tr>
<th></th>
<th>Jan 2009</th>
<th>Oct 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Center</td>
<td>2,701</td>
<td>3,706</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>2,118</td>
<td>2,080</td>
</tr>
</tbody>
</table>

A Matter of Mission and Margin

“You do it because you’re supposed to—either because you’re the sole provider of care for the community, or because if you don’t, you’ll drive the organization into the ground.”

Kellie Valenti
SVP, Ellis Health

## Dictated by Our Own Economics

**Care Transformation Required to Bridge Performance Gap**

### Overall Impact of Market Forces on Hospital Margin

*2021 According to Medicare Breakeven Model*

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current Margin</th>
<th>Projected Operating Margin</th>
<th>After Optimizing Existing Model</th>
<th>After Care Transformation</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>2.2%</td>
<td>(16.9%)</td>
<td>3.9%</td>
<td>4.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Includes impact of:**
- Price growth trends
- Cost growth trends
- Payer mix shift
- Case mix deterioration
- Maximizing revenue capture
- Curbing cost growth trend
- Expanding effective capacity

**Avoidance of excess or unnecessary utilization**

Source: Health Care Advisory Board interviews and analysis.
Broadening Our Definition of Health
Providers Investing in Overall Economic, Social Health of Detroit

Seeing the Bigger Picture
“There is a growing understanding that the health of each institution is directly related to the overall health of the area.”

Susan Mosey
Program Administrator, Live Midtown

Case in Brief: Live Midtown
• Program encourages employees of sponsoring entities to live in Detroit neighborhood through rent or mortgage incentives
• Founding sponsors include Henry Ford Health System, Detroit Medical Center, Wayne State University

Live Midtown Program Initiatives
- Adopting 300 acres of land to rehabilitate buildings into senior housing, research facilities; 17 buildings renovated so far
- Offering subsidies to employees living in Midtown neighborhood; 650 residents granted assistance in 2011
- Leveraging scale to mandate that potential suppliers build in Midtown area

The Advisory Board Company and Population Health

Expertise Spanning Clinical Integration and Population Health Imperatives

**Our Capabilities**
- **Best Practice Research**
- **Leadership Development**
- **Performance Technology**
- **Consulting and Management**

**Our Experience and Assets in Numbers**
- **35** Years experience driving provider performance
- **1,500+** Hospitals using our value-based care technology
- **550K+** Physician profiles on cost and quality performance
- **40%+** U.S. admissions flowing through database
- **10M+** At-risk lives managed using our technology

**Physician alignment**
- Physician engagement in cost and quality goals
- Specialty-specific performance measurement
- Clinically-integrated network management

**Population risk Management**
- Population identification and stratification
- Total cost of care management
- Contract-specific performance tracking

**Proactive patient care**
- Care gap identification and reporting
- Cross-continuum care management workflow
- Patient engagement in self-management goals

**Referral management**
- Seamless referral transfer and acceptance
- Network leakage detection and prevention
- Streamlined appointment scheduling
ReBUILDing Health Care

Improving Health Through Innovative Collaboration
Meet the Partners

By forging this complex partnership, these partner organizations hope to inspire similar teamwork between organizations at the community level.

- Global technology, research, and consulting firm
- Partnering with 200,000+ leaders in 4,500+ organizations across health care and higher education
- Innovative grant-maker focused on strengthening and transforming public health
  - $4.1 million in grants in 2013
- Private philanthropic organization focused on expanding opportunities in American cities
  - $128 million in grants in 2013; $17.7 million made available for Program-Related Investments
- Nation’s largest philanthropy focused solely on health
  - $400 million in grants, annually
  - ($9.2 billion in assets)
- Third-largest health-focused foundation in the country
  - $2.3 billion in assets
  - $100m in grants and contributions awarded in 2013 to improve health in Colorado

©2015 The Advisory Board Company • advisory.com
A Vision Designed to Push Innovation

Objectives
To increase the number and effectiveness of hospital, community, and public health collaborations that improve health and lower costs.

As a result, this initiative will:

- Increase resources and attention devoted to solutions that address social determinants of health
- Identify and promote replicable, scalable best practices
The BUILD Pillars

**Bold**
Innovative solutions that bring forth new ideas for addressing complex problems

**Upstream**
Focus on social, environmental, and economic factors that have the greatest influence on health

**Integrated**
Partnership between a hospital or health system, a non-profit organization, and a local public health department (at minimum)

**Local**
Solutions that are deeply rooted in and led by the urban neighborhood for which the proposal is written

**Data-driven**
Innovative uses of data and information sharing to identify needs and opportunities and measure outcomes
## Two Types of Awards: Planning and Implementation

### Planning Awards
Collaborations in need of support developing a well-defined community health improvement action plan.

- **11** Planning Awardees
- **$75K** in Grant Dollars
- **1 Year** Duration of Funding

Sample activities include:
- Analyzing data and research
- Developing strategic plans
- Engaging community stakeholders
- Convening local partners to define roles and responsibilities
- Mapping organizational assets

### Implementation Awards
Collaborations that have already developed a well-defined action plan and where an infusion of philanthropic support could accelerate their work.

- **7** Implementation Awardees
- **$250K** in Grant Dollars
- **2 Years** Duration of Funding
- **1:1** Match from Hospital/Health System Partner

Sample activities include:
- Advancing local policy
- Expanding partnership
- Supporting staff to manage the initiative
- Developing robust data-sharing agreements
- Strategic communications
- Program evaluation
Incubators of Change one Neighborhood at a Time
A Nationwide Call to Redefine the Model

Cleveland partnership awarded $250,000 grant for work on asthma, lead prevention in homes

BROXN Healthy Buildings Program to improve living conditions

©2015 The Advisory Board Company • advisory.com
New Approaches to Healthy Housing

Stockyards Clark-Fulton Brooklyn Centre Neighborhood of Cleveland

Project Goals

1. Expand home interventions for families with asthma in partnership with MetroHealth hospital, health departments, and local non-profits while working toward establishment of sustainable reimbursement

2. Create a pilot healthy homes zone for targeted community action and home health hazard interventions aligned with engagement of code enforcement entities to support preventive housing maintenance
Workforce Development & Smoking Cessation

Project Goals
1. To create career paths for low-wage, incumbent Cleveland Clinic employees and vendors
2. To facilitate entry-level employment for area residents
3. To reduce tobacco use, from both a health improvement and increased employment perspective

Project Impact
- **Increased economic health**: reduction in unemployment, boost in wages and job retention
- **Increased physical health**: greater access to healthcare benefits and reduction in tobacco use

6.7% 7,500 2.1
Percentage of GUC employees that are local Residents Number of jobs recently & to be added in next five years Cash match promised by Cleveland Clinic to the project (1:1 is required)
Houston Increases Food Access

Project Goals

1. **Launch**: Launch a food system in North Pasadena that is healthy, sustainable, affordable, accessible and community-supported

2. **Production**: To create a community-supported agriculture campus to include CSA vocational training and secondary education programs

3. **Distribution**: To expand the number of healthy food distributors and suppliers to reverse food desert conditions and serve as pipelines for CSA production

4. **Consumption**: To integrate prescriptions for healthy food into the health care system
A CEO’s Vision for Success

...[our BUILD Health proposal] ...supports our transition from a fee-for-service to a population health environment, where payers support methodologies that reimburse for comprehensive care, coordinated and managed to achieve both improved health and lower overall expenditures.

Faced with aging facilities, new technologies and innovative care delivery models, we uncovered an incredible opportunity to address the changes in health care while planning health care delivery for the future.

The BUILD Health Challenge and its principles align perfectly with [our health system’s] current transformation activities that include:

- Engaging community members and stakeholders.
- Connecting local businesses, especially small and minority business owners, with bidding processes and opportunities through the 6-year transformation period.
- Igniting economic development....
- Establishing convenient, new access points across [our county]....

Access to interventions such as those proposed through this BUILD Health initiative would give our providers a powerful tool to help families manage and control this chronic disease and serve as a model for addressing other environmental concerns.

I am confident that this project will show that addressing social determinants of health results in measurable improvements in both health outcomes and health care cost savings. .......
(Finally) reBUILDing Health Care for our Population

Putting the Patient at the Center of the New Health System

Integrated Health Management
- Part of patient day-to-day activities
- Personalized to individual
- Clear, actionable goals

Collaborative Specialty Care
- Collaborative with primary care to set one comprehensive care plan across providers
- Coordinated across continuum

Personalized Primary Care
- Team available to patient for access, education, decision support
- Focus on both chronic and preventive services
- Incorporates health activities

Outcomes-Driven System Activation
- Sensitive to minor changes in individual health status
- Tracking to identify target groups for prioritization, targeted community needs

Convenient Sites of Care
- Available when and where patient needs care
- Easy to find, low-acuity options
- Augmented with virtual access points to address needs, conduct follow-up

Patient Access to Information
- Intuitive access to care plan information, ongoing management guidance
- Reliable and comprehensive sources to support patient engagement

Community Partner
- Collaborative with employers, community groups
- Streamlined across market resources
- Target underlying drivers of population health

Source: Health Care Advisory Board interviews and analysis.
Incubators of Change one Neighborhood at a Time