

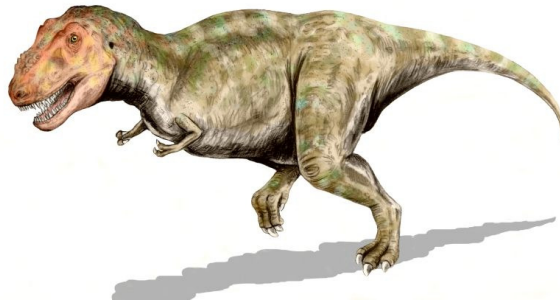


# *Re***BUILDing** Health Care

*Population Health Summit III*

## Crowning Achievement of a Species

History's Most Successful Dinosaur—At a Museum Near You



*Tyrannosaurus*; Credit: Nobu Tamura

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



*Tyrannosaurus Sue*; Credit: Magnus Manske

**“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.<sup>1</sup>*

1) As quoted in Apple Confidential 2.0: The Definitive History of the World's Most Colorful Company (2004) by Owen W. Linzmayer.  
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Source: WikiQuote, Steve Jobs, available at:  
[http://en.wikiquote.org/wiki/Steve\\_Jobs](http://en.wikiquote.org/wiki/Steve_Jobs), accessed May 4, 2011.;  
Health Care Advisory Board interviews and analysis.

# 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<sup>1</sup>

**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

<sup>1</sup>) Includes CV disease, cancer, diabetes, chronic respiratory diseases.



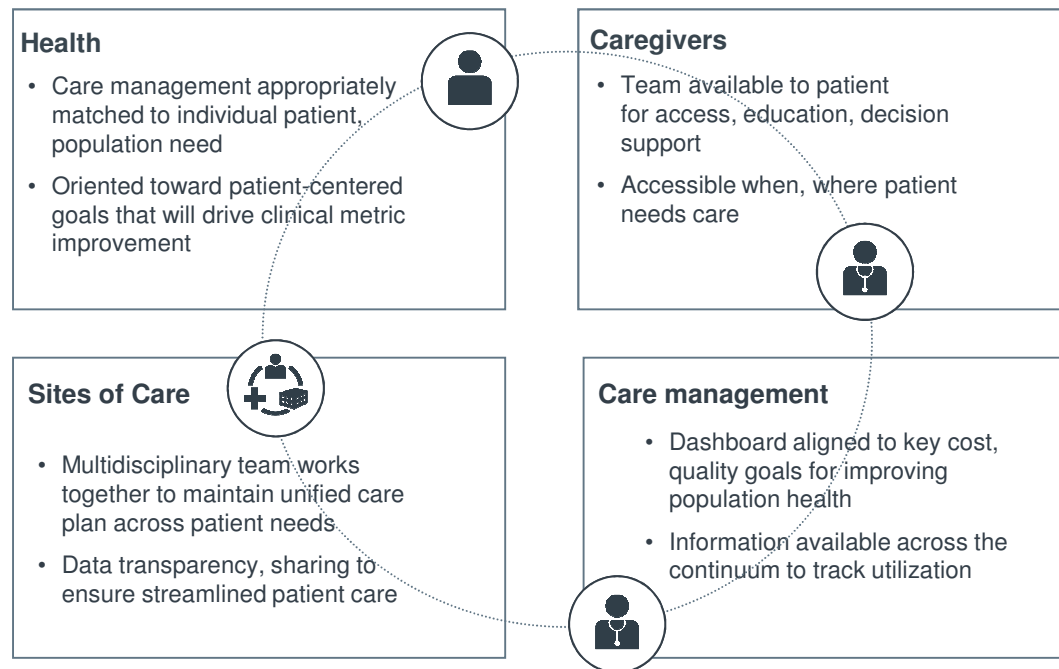
If We Were Building from

**SCRATCH**

*Assembling the Ideal Health Care Solution*

# If We Were Building from Scratch...

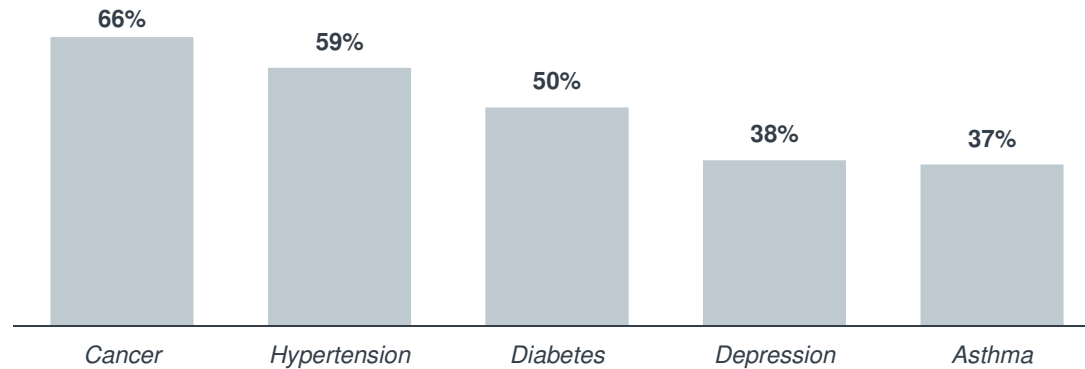
## Assembling the Ideal Health Care Solution



## Facing a Large Gap-to-Goal Today

Overwhelmingly, Patients Do Not Follow Their Care Plan

### Patients Who Strongly Agree They Follow Treatment Regimens Carefully



1 in 2

Adults with one  
or more chronic  
conditions

50%

Chronic condition  
patients with poor  
medication adherence

## Slide 7

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**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

Source: Hibbard JH, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' Scores," *Health Affairs*, 32, no. 2 (2013): 216-222; Osterberg L, Blaschke T, "Adherence to Medication," *New England Journal of Medicine*, 353, no. 5 (2005): 487-97; Mohanan S, et al., "Obesity and Asthma: Pathophysiology and Implications for Diagnosis and Management in Primary Care," *Experimental Biology and Medicine*, (2014); Tsai C, et al., "Factors Associated with Frequency of Emergency Department Visits for Chronic Obstructive Pulmonary Disease Exacerbation," *Journal of General Internal Medicine*, 22, no. 6 (2007): 799-804; Health Care Advisory Board interviews and analysis.

**Slide 8**

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**A2**

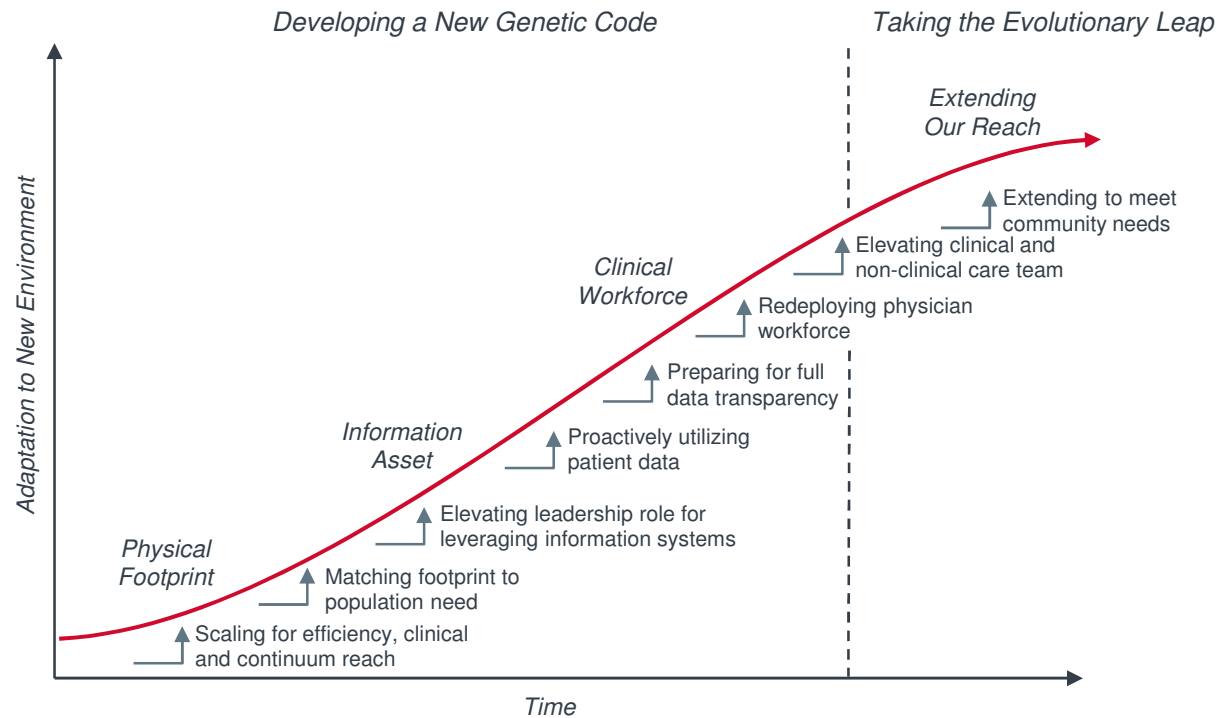
If BUILD could address engagement on

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



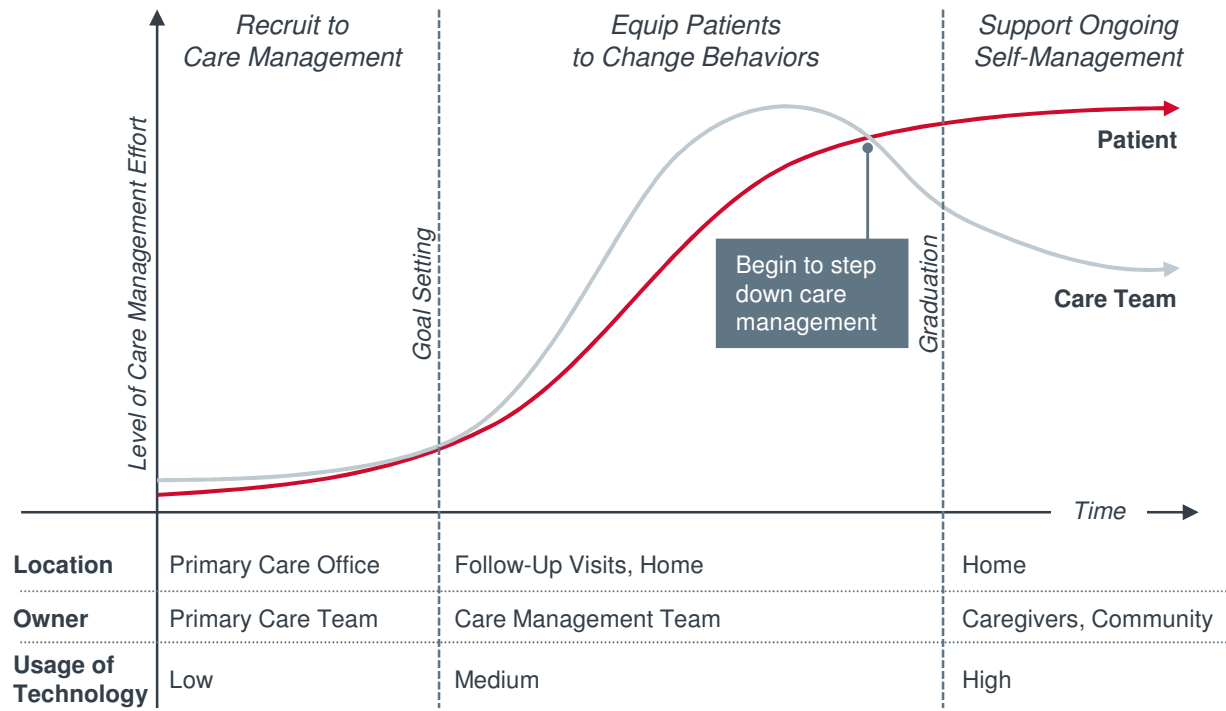
## Revising the Playbook for 2020

### Anticipating Fundamental Changes in Our Approach

	Playbook for 2012	Playbook for 2020
<b>Redefining the Footprint</b>	<ul style="list-style-type: none"> <li>Secure scale for operational efficiency, contract negotiation</li> <li>Ensure seamless transfer from acute care to post-acute, primary care</li> </ul>	<ul style="list-style-type: none"> <li>Leverage partnerships as assets to ensure full continuum reach, bring best-in-class care local</li> <li>View scale through lens of clinical expertise, continuum reach</li> </ul>
<b>Leveraging the Information Asset</b>	<ul style="list-style-type: none"> <li>Prioritize Meaningful Use requirements to earn bonus, avoid penalty</li> <li>Begin to forge connections with other providers working with the same patient population</li> </ul>	<ul style="list-style-type: none"> <li>Utilize enterprise network to inform care pathway development, conduct analytics to determine population need</li> <li>Expand reach into patient home with continuous monitoring, proactive support</li> </ul>
<b>Transforming the Clinical Workforce</b>	<ul style="list-style-type: none"> <li>Secure profitable specialist alignment</li> <li>Engage and secure PCP access and referral chains</li> <li>Shift PCPs to medical home practice</li> </ul>	<ul style="list-style-type: none"> <li>Balance local and virtual workforce</li> <li>Utilize PCP as leader of care team</li> <li>Engage non-clinical peers to maximize patient outreach and support</li> </ul>
<b>Realizing Our New Reach</b>	<ul style="list-style-type: none"> <li>Begin to identify populations—such as employees—to pilot accountable care opportunities</li> <li>Pursue payer or employer pilots to test new care delivery models</li> </ul>	<ul style="list-style-type: none"> <li>Mobilize community leaders to improve overall neighborhood health and wellness</li> <li>Partner to connect with, not re-create, highest-value community resources</li> </ul>

# From Goal Setting to Graduation

## Design the Process for Self-Management Success



# 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

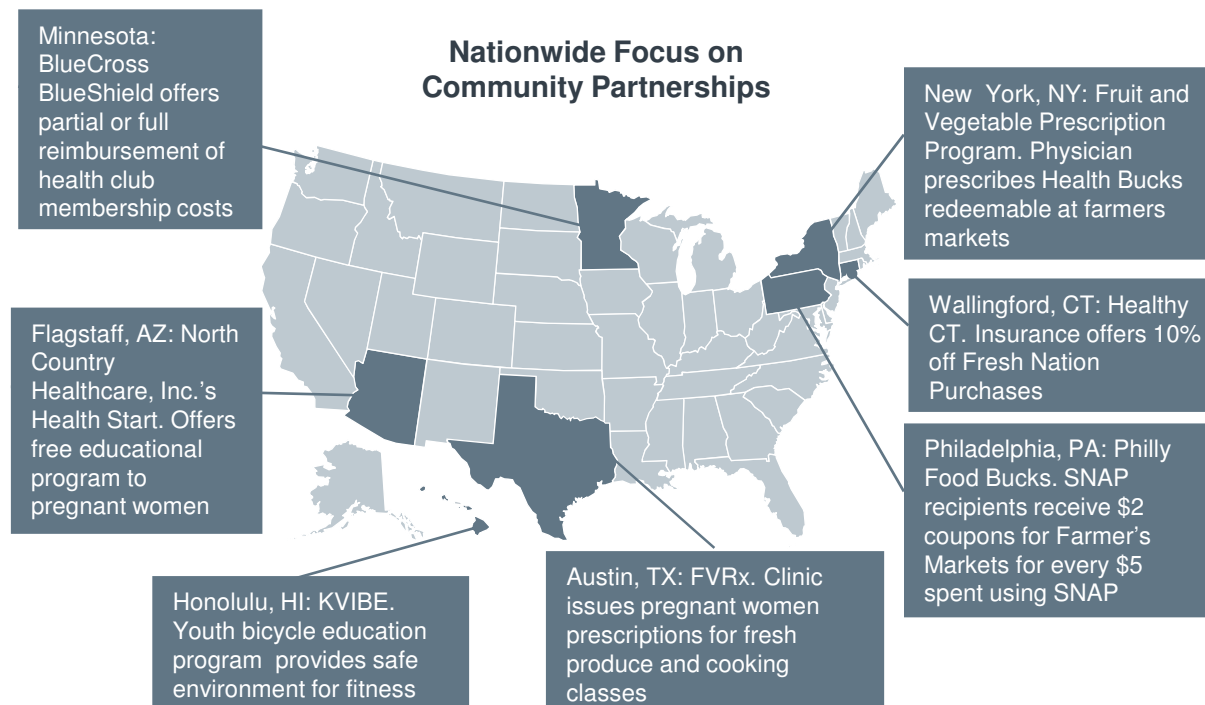
**3**

## 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

## Innovation Focused on Community Health

Partner with Organizations to Align Resources for Ongoing Management



## 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)

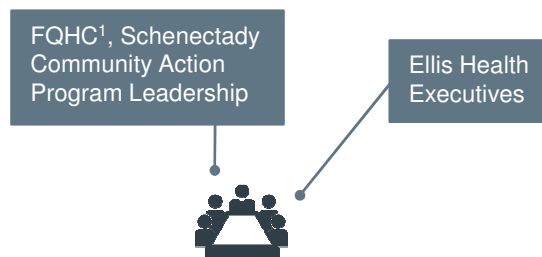
- Joint venture between Duke University Health System, a multi-hospital system including an academic medical center and two community hospitals, headquartered in Raleigh-Durham, North Carolina, and LifePoint, a 52-hospital system with locations in 17 states, headquartered in Tennessee
- Combined strengths 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



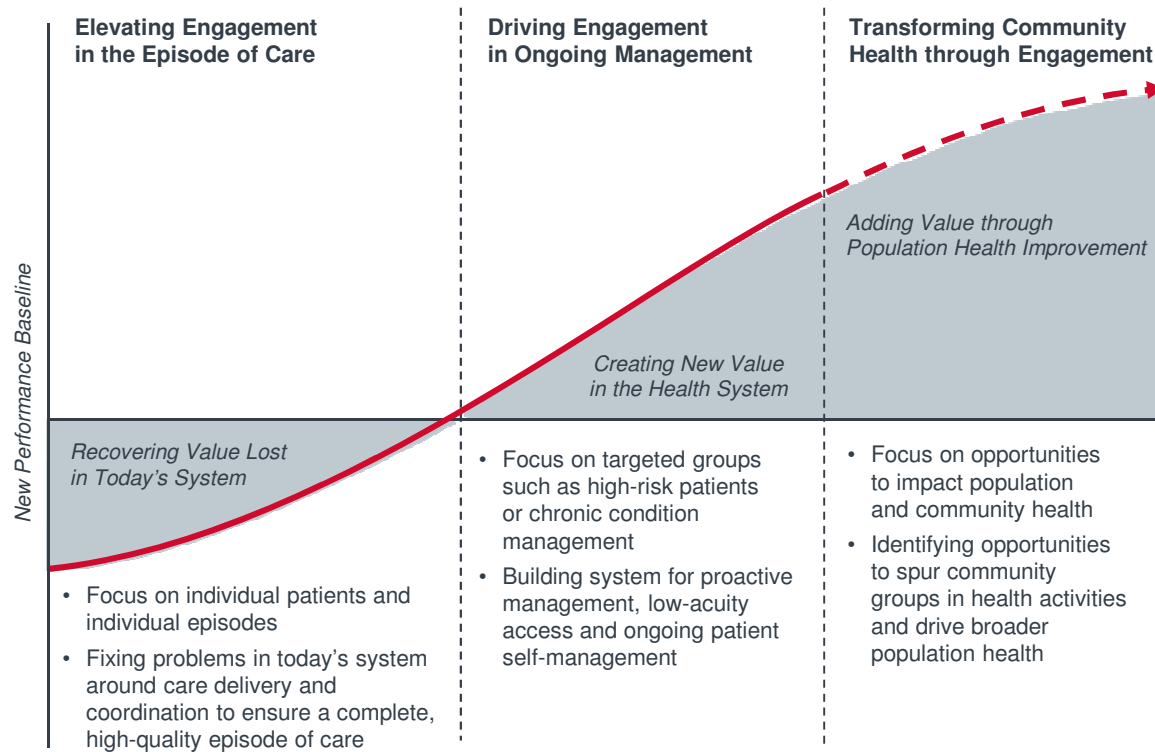
Identified understanding culture of poverty, relationship to ED utilization as priorities



Established common language and nomenclature for continued group momentum, collaboration, and innovation

# Competing on Patient Engagement

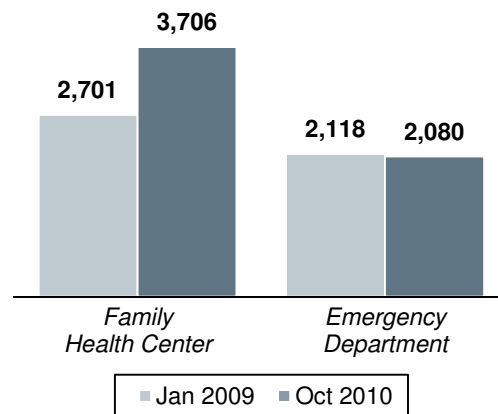
## Phases of Health System Value Creation



## Good for the Community, Good for the Organization

### Shifts in Utilization Patterns Generate Financial Returns

#### Number of Visits to Family Health Center, Emergency Department



## \$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<sup>1</sup> services from 2009 to 2010

“

#### 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*

1) Services include Family, Pediatric Health Centers, Adolescent Mental Health Program, Dental Clinic.  
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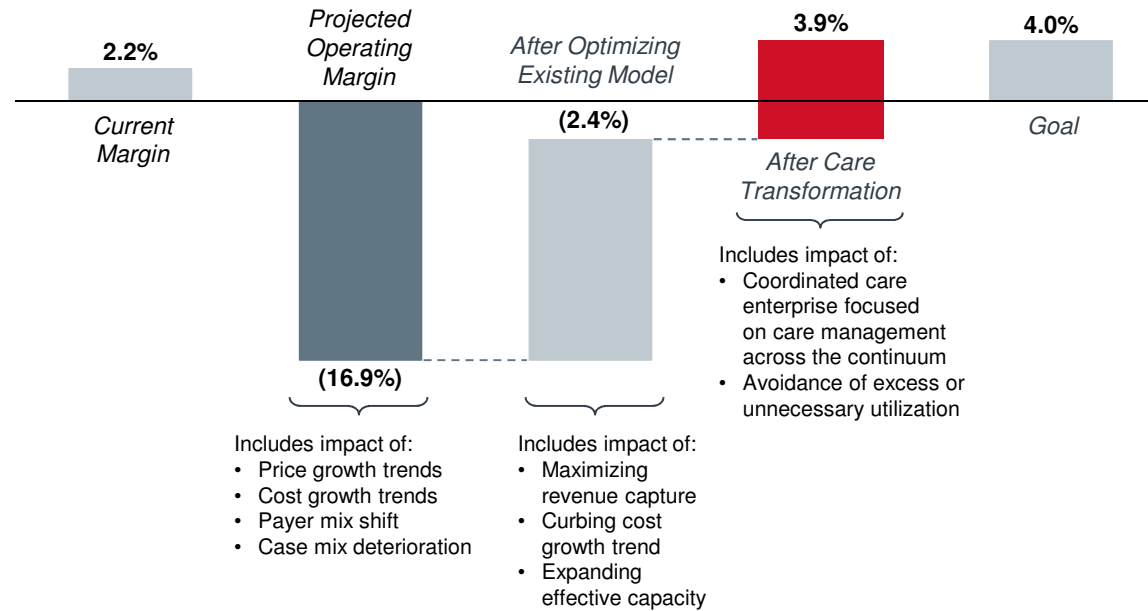
Source: Valenti K, “A Hospital-Owned, Facility-Based Medical Home: Lessons from Ellis Medicine,” presented at: The National Medical Home Summit, March 14, 2011, Philadelphia.; Health Care Advisory Board interviews and analysis.

# 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



# 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



# The Advisory Board Company and Population Health

## Expertise Spanning Clinical Integration and Population Health Imperatives

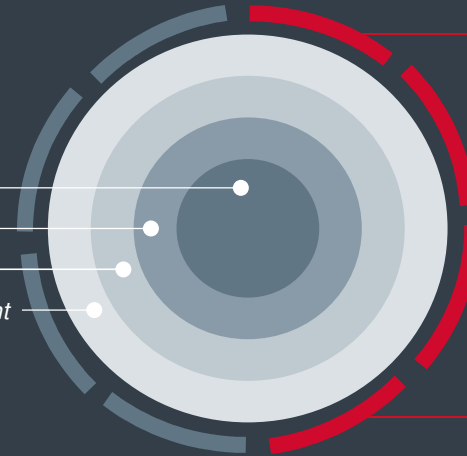
### Our Capabilities

*Best Practice Research*

*Leadership Development*

*Performance Technology*

*Consulting and Management*



### 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

### 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

# ReBUILDing Health Care

Improving Health Through Innovative Collaboration

The  
**BUILD  
HEALTH**  
Challenge



## 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



## 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

# The BUILD HEALTH Challenge

---

### **Bold**   **Upstream**   **Integrated**   **Local**   **Data-driven**

Innovative solutions that bring forth new ideas for addressing complex problems

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

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

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

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

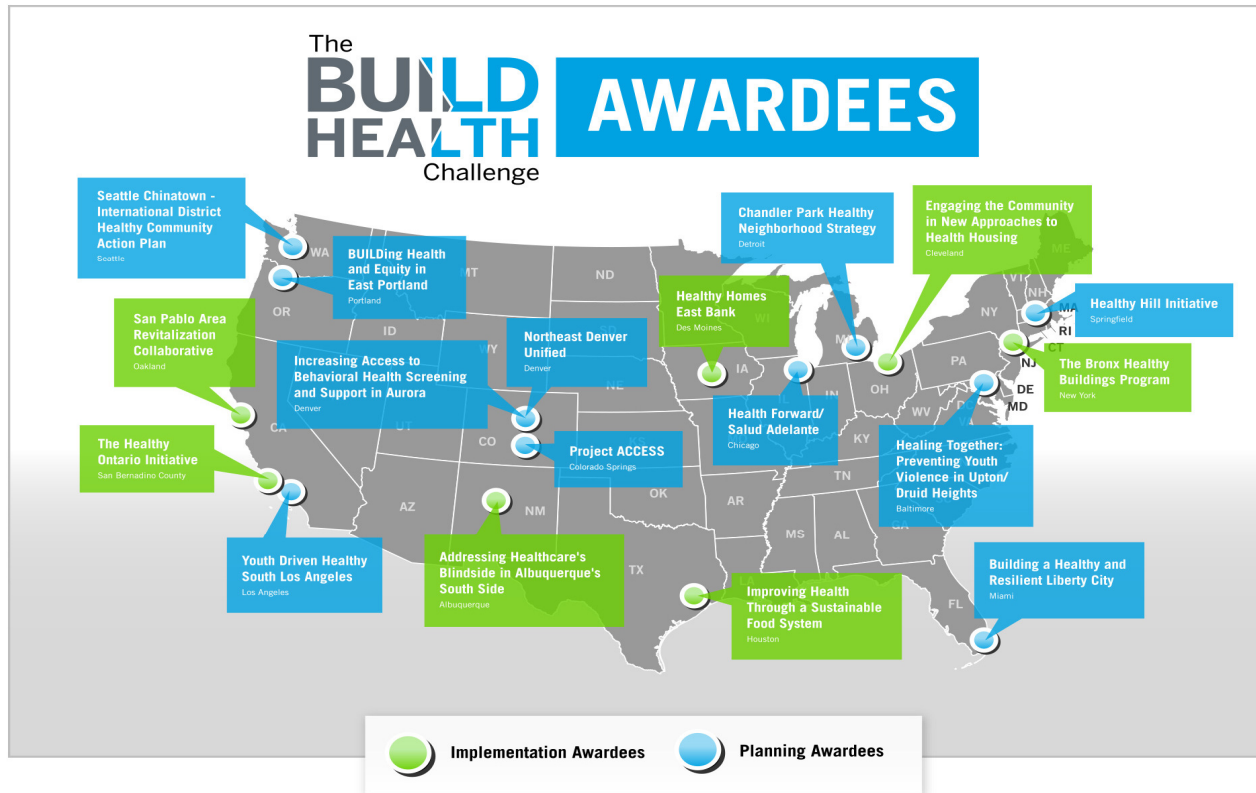
**1:1**

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



**The Des Moines Register**  
A GANNETT COMPANY

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HOME NEWS CAUCUSES SPORTS THINGS TO DO BUSINESS COMMUNITIES OPINION Slider ARCHIVES USA TODAY

### Program targets air quality in older D.M. homes

By Timothy Meinch, [tmeinch@dmreg.com](mailto:tmeinch@dmreg.com) 8:17 p.m. CDT June 15, 2015



Half-a-million dollars in grant funding will target childhood asthma by improving deteriorating housing in three Des Moines neighborhoods.

The new collaborative effort, Healthy Homes East Bank, launches Wednesday for the Capitol Park, Martin Luther King Jr. Park and Capitol East neighborhoods. Viva East Bank, a public-nonprofit coalition, formed last year in an effort to revitalize those three neighborhoods just east of downtown over the next five years.

Healthy Homes launches this week with a \$250,000 grant from the national BUILD Health Challenge. Area hospitals added \$250,000 in matching funds.

\*The end game is more healthy and safe homes, healthier neighborhoods and

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cars.co  
ALL DRIVE. No  
ADEL CHRYSLER DODGE RAM JEEP  
HYUNDAI KIA MAZDA  
Subaru

TOP VIDEOS

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



Akbar Tyler, an inspector with Environmental Health Watch, visits homes in Cleveland to check for mold, lead paint, standing water, roaches, animal droppings—anything that would be an asthma trigger or health hazard. The BUILD grant will help that organization, along with the Cleveland Department of Public Health and the MetroHealth System, to continue this work in three Cleveland neighborhoods. (Lynn Ischay, The Plain Dealer)

By Eric Zeltner, The Plain Dealer  
Follow on Twitter  
on June 13, 2015 at 7:00 AM, updated June 15, 2015 at 8:01 PM

CLEVELAND, Ohio — A partnership between the Cleveland Department of Public Health, the MetroHealth System, and the non-profit Environmental Health Watch

#### SHOCKING! End of OWN?



LEAKED Secret Might Bring Down an Empire  
See The Secret She Hid From The World

#### HEALTH & FITNESS BEAT

- Brie Zeltner, Plain Dealer health reporter
- Casey Ross, Plain Dealer health reporter



**A Nationwide Call to Redefine the Model**

**BRONX Times**

July 9, 2015: 2015, Issue 27

Classifieds

**STANLEY STEEMER. \$99 FALL CLEANING SPECIAL**

JULY 9, 2015 / NEWS / BRONX TIMES / BRONX TIMES REPORTER

INITIATIVE TARGETS NORTHWEST AND CENTRAL BRONX NEIGHBORHOODS

### Bronx Healthy Buildings Program to improve living conditions

By Robert Wirsing

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Email | Submit | Like (3.7k)

A new health conscious building initiative seeks to provide some deeply plagued Bronx neighborhoods with a cleaner bill of health.

On Tuesday, June 9, Montefiore Health System, the New York City Department of Health and Mental Hygiene, and the Northwest Bronx Community and Clergy Coalition, in collaboration with local partners, were awarded \$250,000 by the BUILD Health Challenge to implement the Bronx Healthy Buildings Program.

This initiative targets the northwest and central Bronx's deteriorating housing



## New Approaches to Healthy Housing

### Stockyards Clark-Fulton Brooklyn Centre Neighborhood of Cleveland



CUYAHOGA COUNTY  
BOARD OF HEALTH  
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION



STOCKYARD, CLARK-FULTON  
& BROOKLYN CENTRE  
COMMUNITY DEVELOPMENT OFFICE



#### 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



CUYAHOGA COUNTY  
BOARD OF HEALTH  
JK TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION



### 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%**

Percentage of GUC employees that are local Residents

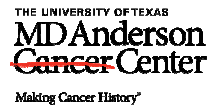
**7,500**

Number of jobs recently & to be added in next five years

**2.1**

Cash match promised by Cleveland Clinic to the project (1:1 is required)

# Houston Increases Food Access




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## Project Goals

1. **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.*

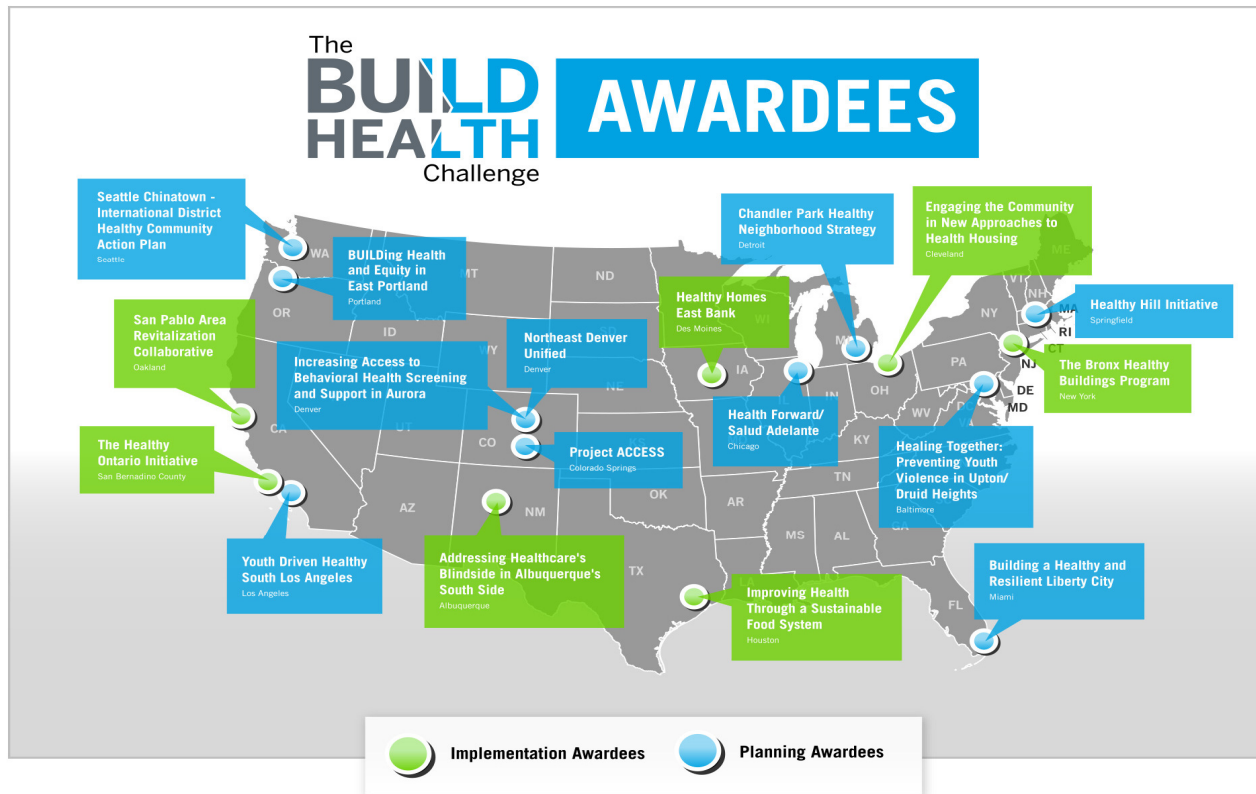
*I am confident that this project will show that addressing social determinants of health results in measurable improvements in both health outcomes and health care cost savings. ....*

# (Finally) reBULding Health Care for our Population

## Putting the Patient at the Center of the New Health System



# Incubators of Change one Neighborhood at a Time





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