CHRISTENSEN INSTITUTE

YOU ARE WHAT YOU TREAT:

Transforming the health care business model so companies—and people—thrive

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EXECUTIVE SUMMARY

Over the past two years, the world has experienced unimaginable challenges due to the COVID-19 pandemic, with health care organizations continually on the front lines of battle. Organizations that survived did so at both clinical and financial costs. This survival came with many lessons learned, such as the lack of resiliency exhibited by fee-for-service (FFS) business models. As procedural volumes fell amidst the pandemic, these models saw their financial margins disappear. Yet, as the world continues to emerge from the effects of the pandemic, health care entities continue to battle challenges associated with falling reimbursement, rising costs, and the threat—or promise—of a shift to value-based care looming just over the horizon.

With the added responsibility to address drivers of health (DOH), also known as social determinants of health, pressure is mounting to create health, not just treat sickness. The FFS business models of the past impede progress toward a healthier future for patients and a more financially sustainable one for health care organizations. To thrive in the future, health care organizations need a transition plan to remain financially viable and continue to serve their communities. This paper provides a compass to guide the transition.

When we analyzed the health care landscape, we found that the vast majority of today's organizations can't successfully and sustainably address DOH to improve people's lives. This isn't because leaders are incapable or unwilling. Most organizations simply don't have the business models required to make the desired impact. Traditional business models are set up to succeed in the FFS, "sick care" business, not the value-based business of improving health by addressing the root causes of disease. As a result, health care organizations need a fresh start. They need new business models to address drivers of health and create better lives for individuals and communities.

In this paper, we provide a data-driven and theory-driven analysis for why this is the case, and guidance leaders can follow to design or redesign their business models. By transforming value propositions, resources, processes, and profit formulas, health care organizations can embark on a path to thrive in the future.

INTRODUCTION: WHAT ARE DRIVERS OF HEALTH AND WHY ARE THEY IMPORTANT?

Imagine arriving home from the grocery store to find that while you paid $90, you only received $15 worth of food. You thought you bought food for the week, but in reality, you only have 10 to 20% of what you need. Given the outsized spending on food to cover one to two days, you have little funding left to cover the remaining five to six days. Maddening and unbelievable? Perhaps for groceries, yet this is what Americans tolerate for health care every day in the United States.

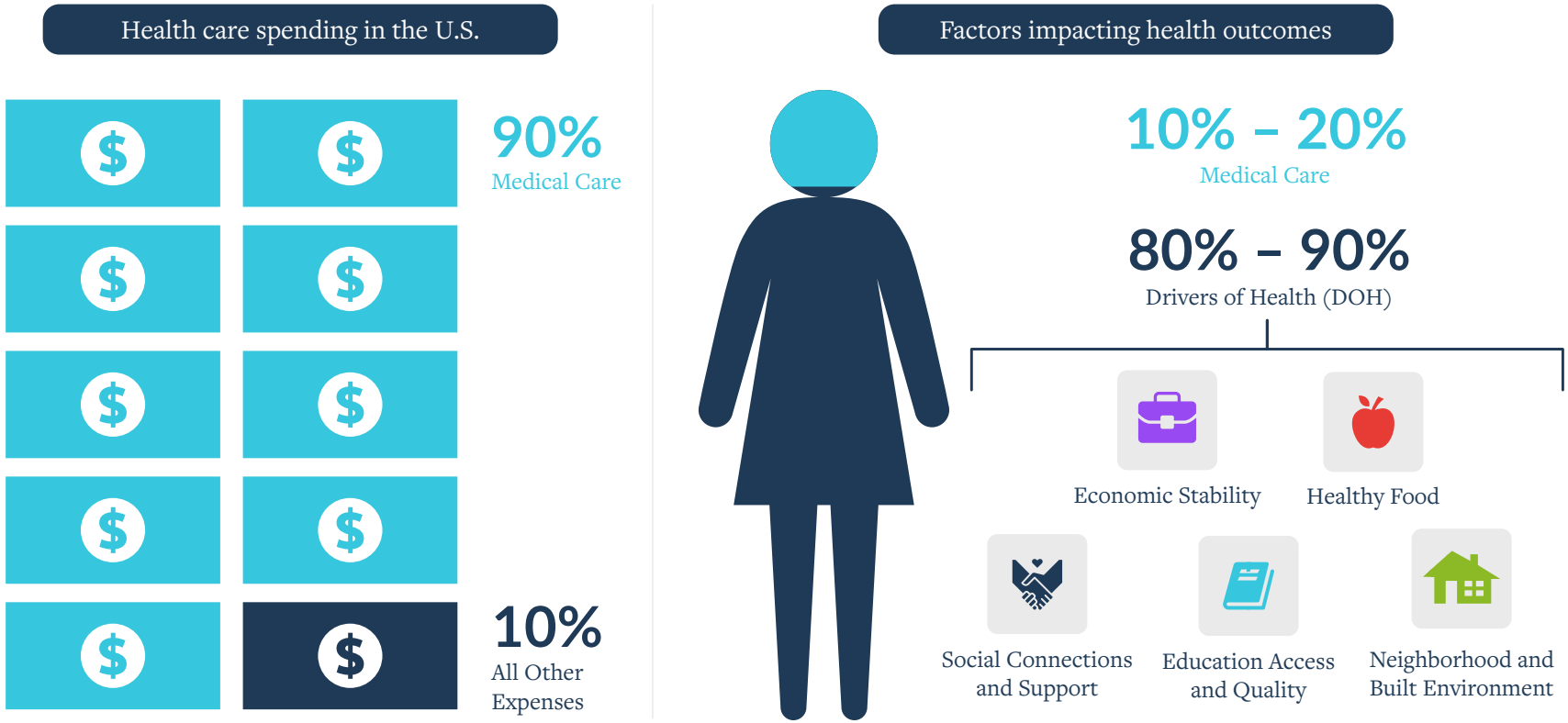
Nationally, 90% of health care spending is allocated to medical care, which only accounts for 10-20% of health outcomes.[1,2] The United States pays roughly 600% more for medical care than it should. Recent research from the Commonwealth Fund shows that despite spending the highest percentage of gross domestic product (GDP) on health care, the US has the worst outcomes of high-income countries.[3]

Drivers of health (DOH), also known as social determinants of health, account for up to the remaining 80 to 90% of health outcomes, and there is now widespread recognition that reducing health disparities and improving health outcomes depends on addressing these drivers.[4,5,6] (See Figure 1.) For example, the same research from the Commonwealth Fund also reveals that countries with better health outcomes invest more in social services and in equitable, ubiquitous primary care—that is, these countries invest upstream to improve people's health.[7]

DOH include all the circumstances in a person's life that affect their health and quality of life (QoL) status. These include access to quality health care, plus predominantly non-medical factors, such as education access and quality, access to and affordability of healthy foods, social connections and support, stable employment and housing, safe neighborhoods, clean air and water, and more. (See the sidebar "The case for drivers of health".)

The United States pays roughly 600% more for medical care than it should.

Figure 1. The mismatch between health care spending and health



Why isn't the system investing in what improves people's health and their lives? Because the health care ecosystem doesn't incentivize prevention. By and large, an industry's ecosystem reinforces what types of business models will succeed. Reflecting on health care, Paul Batalden famously stated, "Every system is perfectly designed to get the results it gets."[8] The current ecosystem incentivizes provider organizations to perform services that treat illness instead of those that keep people healthy. And these fee-for-service (FFS) incentives perpetuate business models built around the FFS profit formula. The result is a health care ecosystem that pays to treat illness, not one that invests upstream to create health and improve lives.

Falling reimbursement, rising costs, sicker populations, and a host of other challenges make the current state of health care business models undesirable and financially unsustainable. As a result, the industry is on a journey to reset its ecosystem, and the slow shift from FFS to a value-based care system that addresses DOH is continuing to gain steam. When the Affordable Care Act (ACA) was passed in 2010, the amount of attention health care leaders paid to DOH sharply increased. This was the result of multiple components of the ACA, namely the requirement for nonprofit hospitals to perform community health needs assessments (CHNAs) and develop strategies to address these needs every three years. The Centers for Medicare and Medicaid Services' (CMS) Innovation Center also launched multiple programs focused on social needs, which enhanced the industry's

discussion and efforts around DOH, and CMS updated reimbursement methods to incentivize DOH interventions.

A decade later, a 2021 research report from Deloitte highlighted that growth in value-based care models is leading executives to invest more in DOH efforts, and the percentage of leaders doing so is on the rise. In 2017, only 20% indicated this growth was a driver for DOH investments, but in 2021, the percentage grew to 58%.[9] However, these efforts are still ad hoc, disconnected, and falling short of creating their desired impact to address health inequities, improve health outcomes, and lower the cost of care.[10]

Aiming to uncover the root cause of this challenge, our research revealed that many leaders have been seeking to address DOH from within their existing business models. The problem is, they can't. This isn't because they don't want to, but because their business models won't allow it. Business models define what organizations can and can't do. They identify what opportunities an organization finds attractive based on the incentives of its profit formula, and what resources and processes exist to support those opportunities. When an effort, like addressing DOH, doesn't fit neatly into an organization's existing business model, it almost always fails.

In short, an old business model can't deliver on a new value proposition. What works in today's FFS environment will not work in the future's value-based care environment. To improve health and people's lives within a financially sustainable business model, health care entities need a new approach to how they do business—and some early innovators are beginning to pave the way.

In stark contrast to today's FFS business models, our research revealed that innovators are building new business models around four key components:

1. Addressing consumer's and customer's desired progress;[11]
2. Establishing payment models that incentivize serving those needs;
3. Measuring what matters to those they serve; and
4. Connecting dots across the disconnected ecosystem to achieve these goals.

Leaders of traditional organizations can learn from innovators' approaches as they seek to thrive in tomorrow's environment.

The case for drivers of health

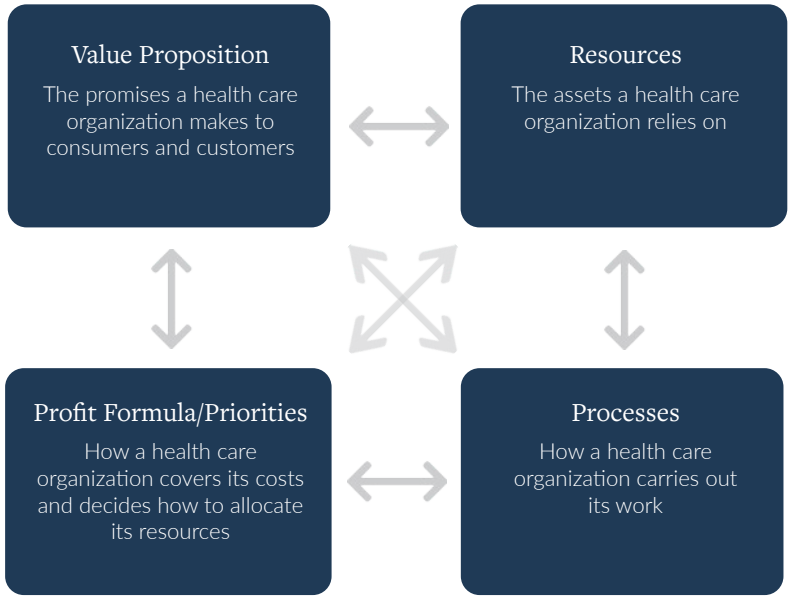
The health care industry traditionally uses the term "social determinants of health" (SDOH) to refer to the societal, population-level structures that influence health outcomes. But there are multiple competing definitions for SDOH, all suffering from a high level of complexity and the exclusion of the individual's perspective.

"Drivers of health" (DOH) offers clearer language to encapsulate the individual's ability, and the health ecosystem's necessity, to improve the causal drivers of people's health and life outcomes. These structures that drive health outcomes are *drivers*, not *determinants* set in stone. The DOH phrase challenges the assumption that these factors are predetermined and highlights our individual and collective agency to drive change, enhancing health and life outcomes for all people. Lastly, it addresses the limiting nature of the word "social," as drivers of health encompass the social, environmental, and economic systems that influence how people live, work, play, pray, and age.

BUSINESS MODELS DETERMINE AN ORGANIZATION'S CAPABILITIES

The Christensen Institute has a framework to make the business model concept clear (see Figure 2). The framework defines a business model as four interlocking elements that, when taken together, create and deliver value: value proposition, resources, processes, and profit formula/priorities.

Figure 2. The four components of a business model



Note: This graphic was originally published in Clayton M. Christensen and Mark W. Johnson, "What Are Business Models, and How Are They Built?" Harvard Business School Module Note, August 2009 (revised November 2021). It has been modified for this paper to focus on health care business models.

Business models determine an organization or company's capabilities (what it can and can't do) and its priorities (what it must accomplish). This, in turn, defines which innovations it can and will pursue.

The framework is powerful because it enables the prediction of which initiatives will succeed and which ones will fail. It's critical for leaders to understand these four components of a business model so they know what to leverage from their core business when they need to employ a new business model approach.

How business models solidify

The first component of the business model is the **value proposition**, or the set of value propositions, a company offers to its customers. These are the promises an organization makes to fulfill customer needs or goals. Most businesses have multiple value propositions, which are delivered to customers as products or services.

Resources are required to deliver value propositions. These are assets—people, technology, products, facilities, equipment, brands, and cash—that can be both tangible and intangible.

As an organization works to deliver its value propositions repeatedly and effectively, **processes** emerge. These are the habitual ways of working together that emerge as people address repeated tasks successfully. Some processes are explicitly stated, documented, and followed. Others are unstated and executed as part of the unspoken culture. Examples include training, budgeting, planning, performing a well-visit exam, etc.

To cover all the costs associated with the resources and processes needed to deliver on the value propositions, and establish a margin to promote sustainability, organizations create a **profit formula**. This defines how the company will maintain viability and sustainability to support its cost

structure over time. To support its profit formula, organizations establish **priorities** that encompass policies, rules, and culture to guide investment decisions about how to use resources and processes to deliver the value proposition.

In an organization's early days, when it is operating as a startup, all business model components are flexible. To survive infancy, organizations pivot their value propositions and adjust their resources and processes until they identify how to bring in the revenue they need to survive. Once this is determined, business model components become increasingly interdependent and resistant to change, especially in successful organizations. The ways in which the four components reinforce one another makes the business model highly interconnected, and thus more challenging to alter the longer it exists.

This happens because when resources and processes meet a need or solve a problem, they get replicated, repeated, improved, and standardized. Even though value propositions were an organization's starting point, a mature organization can only successfully deliver value propositions that fit its existing resources, processes, and profit formula. As a result, all four components become interdependent, creating a durable set of capabilities and priorities.

So what occurs when leaders call for a change to the business model? If a proposed innovation creates friction with established capabilities, it won't gain internal traction. Similarly, if it threatens the existing profit formula, it won't survive. As models solidify and strengthen over time, employees become stakeholders with vested interests in supporting how the organization works. If a change or innovation threatens the established way of doing things, stakeholders will use their political power to resist the change and uphold the status quo. This occurs because every resource and process in a settled, successful organization exists to solve a problem for the company and to support delivering the ***established*** value propositions to consumers (a.k.a. patients or members) and customers (a.k.a. payers or employers). Stakeholders resist change that threatens the established model as long as the purpose for which the model was created still exists.

This poses a challenge in our current health care landscape where traditional organizations are seeking to address DOH, which aren't established parts of their value propositions and profit formulas, nor their solidified capabilities that have led to past success.

With this framework as a foundation, let's compare and contrast the business models of those that are making a difference in DOH versus traditional health care business models.

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How incumbents differ from innovators

Incumbent provider business models built to succeed in the FFS environment are optimized to resolve acute health issues. These issues are often associated with one body system and require high levels of medical expertise to resolve. FFS organizations contract with vendors who support their processes to deliver care (i.e., electronic health record companies, group purchasing organizations, etc.), and pay experts (i.e., doctors) to solve acute health exacerbations. Payer business models in this ecosystem are set up to reimburse provider organizations for the services and transactions they perform. While some payer and provider organizations are seeking to shift to business models that are optimized to succeed under value-based arrangements, and thus keep people healthy, the attempts have produced underwhelming results. This is a result of the rigidity of business models described above.

Innovators are flipping these traditional models on their heads by building their businesses around delivering health. They are focused on a whole-person approach to health, addressing social connections, emotional wellbeing, nutrition, physical activity, mental health, and physical health, as opposed to just the physical health characteristics upon which traditional models focus. Because the FFS system doesn't financially incentivize the time and resource-intensive approach required to deliver whole-person care, innovators have developed new payment models and new measures of success that support keeping people healthy instead of "fixing" them once something "breaks." They don't rely on FFS reimbursements, but instead upon value-based arrangements or philanthropic support to fund their DOH efforts. They've also hired new types of resources (community health workers, registered dietitians, health coaches, etc.), and established new processes to build trust and fully understand the consumer's life.

Next, we'll look at a few examples from the field to determine the innovative promise exemplified in their business models.

Conducting the research

To better understand the various approaches organizations are taking to address DOH, we did an initial scan of 84 organizations. They spanned community and faith-based organizations, government organizations, health and hospital systems, integrated payer/provider organizations ("payviders"), payers, potential disruptors (startups addressing nonconsumption and/or overserved consumers in the market), and enablers (those who don't provide direct medical care but support others' ability to address DOH).

We uncovered the drivers of health addressed by each organization, their approach to those drivers—whether they addressed them independently or took a partnership approach—and how each organization measured success to identify potential high-performers.

We then spoke to 15 organizations across categories, targeting organizations based on their reputation as a leader in addressing DOH, or as a result of their published success in improving health-related quality-of-life or lowering care costs. We performed an in-depth qualitative analysis of the interviews and research to identify business model trends and themes. This analysis informed our business model framework to empower leaders to address DOH in a sustainable way and effectively improve individuals' lives.

INNOVATORS IN ACTION

Our landscape scan highlighted that most health care entities engage in some sort of DOH work. To identify leaders in the field, we studied organizations that ranged from providers to payers, disruptors, community organizations, and enablers. (See Figure 3.)

Figure 3. Examples of organizations addressing DOH

Note: This graphic is not intended to be an exhaustive overview of organizations addressing DOH; rather it attempts to illustrate the landscape through a variety of organizational examples.

Our research revealed a number of innovators breaking free from the sick care business models of the past and building new models to create health. Below, we dive into select case studies that highlight promising business models that both disruptors and community organizations are bringing to the field. Then, we highlight a few key aspects of payer and provider approaches that challenge today's status quo. The case studies highlight how innovative business models contrast with the traditional, incumbent FFS models in the health care industry today.

Factor Health

Factor Health isn't a typical payer or provider. Instead, it partners with payers, providers, and community organizations to improve health through interventions that occur outside of traditional care facilities. The model seeks to deliver health within the flow of people's lives.[12]

To demonstrate near-term cost savings and health improvement, Factor Health focuses on addressing individual or family risk factors, such as nutrition insecurity and loneliness, for the under- and uninsured. Interventions are less than one year in length and seek to demonstrate a return on investment (ROI) in less than two years. Perhaps most importantly, Factor Health designs programs around the individual's or consumer's desired progress, in concert with a payer's or customer's desired progress to reduce health care costs.

Since it doesn't operate as either a traditional payer or provider, Factor Health is not wedded to the traditional FFS business model. In creating its health interventions, the organization has taken a unique approach to developing its value propositions and uncovering what both consumers and customers need. Early in the intervention design process, Factor Health asks the payer which consumer health problems cause them the greatest hassle or worry, and where they are willing to run an experiment or take a risk to find a solution. Factor Health then pairs this understanding with what the consumer wants and designs a program that addresses both the customer's and consumer's desired progress.

For example, loneliness is a known risk factor for many chronic conditions.[13] Since there are few effective and scalable interventions to address it, the loneliness epidemic represents both a pain point for payers and an opportunity for innovation.

To test a scalable, low-cost intervention that would improve seniors' mental health, Factor Health rapidly developed a program that leveraged 16 laypeople to have empathetic phone conversations with food-insecure older adults.[14] As part of the program design, each of the older adults determined the frequency of the calls to be received.

In an interview, Factor Health's founder summarized its approach: "The focus of the calls were for the caller to learn about the other person and to prioritize whatever it was that the person they were calling wanted to prioritize....The bottom line is, you're listening as much as possible."[15]

By focusing on what mattered to the consumer while also addressing a customer's pain point, Factor Health helped participants reduce their loneliness, depression, and anxiety scores.[16] As we learned in our interviews, the organization also received feedback from consumers that calls made them happier and more motivated. Overall, the program helped individuals quickly achieve their desired progress—higher quality of life through better mental health status—and did so at a low cost. Identifying an affordable, scalable way to reduce loneliness addresses payers' need for a low-cost, scalable, and effective approach to improve mental health that can reduce the likelihood of chronic condition complications and associated costs.

Factor Health's approach to incorporating consumer's and customer's desired progress into their service design, building their solutions on a foundation of empathy, and then measuring what matters to those they serve, provides an excellent example for innovators and incumbents alike to follow.

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Oak Street Health

Oak Street Health (OSH) is a disruptive primary care model predominantly focused on serving Medicare patients with multiple chronic conditions. Its business model is designed to deeply understand its consumers, keep them as healthy as possible, and receive payment for this value-based approach.

While the CEO has stated that OSH runs "an incredibly inefficient primary care company," and that the "model is expensive" by traditional primary care standards, OSH is, nevertheless, moving the needle on improving people's lives by keeping them out of the hospital.[17] Since opening in 2012, OSH has reduced hospital admissions and ER visits by 51%, while maintaining a net promoter score (NPS) of 90 out of 100.[18] For reference, the NPS of traditional primary care in 2019 was -1.2.[19] While NPS is not the ideal measure to convey what matters most to patients, it's undeniable that 51% fewer visits to the ER is an improvement to an individual's QoL.

OSH's business model characteristics are key to achieving these outcomes. One core capability is its lengthy patient intake process. In contrast to the typical 15-minute primary care visit, care teams spend 80 minutes with new patients to truly understand their lives and health conditions. Through this process, providers and care teams are able to establish trust and deeply understand the patient's contexts and needs. As we uncovered in multiple interviews, deep understanding involves both a quantitative and qualitative view of the patient's situation and struggles, based on both their stories and their quantitative health history.

This holistic view of the individual's health and life circumstances enables OSH to take a whole-person approach to care and identify which health interventions will be effective for each person. Oak Street Health leverages its multidisciplinary care teams, including social workers and community health workers (CHWs), as well as predictive analytics and machine learning to get to the root of their patients' risk factors that will drive hospitalizations.

Since OSH is paid to keep people out of the hospital, the organization is incentivized to prevent negative health outcomes. Its revenue model is based on global capitation, taking 100% of the risk for its patients' medical care and receiving a per member per month (PMPM) payment based on patients' risk scores.

The organization also salaries its providers. Doctors are not incentivized by the number of transactions they perform, and they see a maximum of 10 patients per day. The structure of OSH's business model is key to its ability to deliver on the core value propositions it offers patients: to feel known and to stay "happy, healthy, and out of the hospital."[20]

Good Samaritan Health Center

Good Samaritan Health Center (Good Sam) is a faith-based clinic providing health and wellness services to low-income families in Atlanta, Georgia. It seeks to reverse the health care gap in Atlanta and set families on a path to achieve long-term health. Good Sam built its model on a foundation of offering a whole-person approach to health and care. It views patients' health holistically, acknowledging the multiple drivers impacting an individual's outcomes and quality of life. This approach is referred to as the "Full Circle of Health" model. It addresses physical health and dental care, but also DOH such as nutrition, mental and emotional wellbeing, health education, and physical activity.

To support its ability to deliver on this value proposition, Good Sam established many capabilities to get to know patients, build trust with them, and design services to meet patients' needs and goals. One of these capabilities is a culture that supports creativity at the expense of failure. Good Sam focuses on creating space for learning, mindfulness, and empathy development. As our research uncovered, the clinic is grounded in a process of "seeing the need, talking to the community, trying it, and asking, 'Does it work?'"[21]

An impactful story about its homeless clinic highlights the power of its capabilities in delivering value to consumers. The clinic started as a pilot where Good Sam set aside one Friday per month to serve the homeless population. On the first day, three complex patients with multiple challenges showed up, and it took the entire day to serve their needs. This taught Good Sam that there was, indeed, a need in the community.

To improve the service, the team kept refining the program based on consumer feedback. The program has grown from seeing three patients on the first Friday, to now seeing 40 or more. As a result, Friday is now a no-appointment day, specifically reserved for people who are currently

homeless, to address their integrated needs across Good Sam's Full Circle of Health model.

Interviewing people to understand why they came on Fridays and what progress they achieved was core to the design of this offering. Through interviews, Good Sam's leaders and providers uncovered the importance of meeting people where they are and learning what matters to patients. They learned that recognition was paramount, and that patients came back to Good Sam because someone remembered their name, providers were like family, someone cared about their story, and doctors asked the patient about it the next time they visited.[22]

Almost 70% of the homeless patients who come on Fridays return for suggested follow-up care, and this is a result of the caring and respectful environment Good Sam has created.[23] A core process that enables this trust to develop is not to overschedule providers, ensuring that they have adequate time with the patient, and also have time to make a warm handoff to mental health or housing partners with whom the patient may need a connection.

In addition to its processes to establish trust, learn what matters to patients, and build offerings around those needs, Good Sam places an emphasis on partnerships. Its partnership ecosystem is made up of nutrition and housing providers, health systems for higher acuity services, medication providers, community- and faith-based organizations, and more to help deliver multiple services addressing patients' DOH.

When discussing profit formulas, Good Sam leadership noted, "The less you are tied to fee-for-service reimbursement, the more you get to address social determinants of health."[24] The majority of Good Sam's funding comes from philanthropy.

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Humana and Jefferson Health

As leaders consider how to structure their businesses to meaningfully impact DOH, they can learn from organizations taking a new approach to priorities. These organizations are focusing on measuring what matters most to the individuals they serve.

Humana offers one example. In 2015, it launched a population health strategy and stated a "bold goal" to systemically address social determinants of health and deliver more healthy days for its members and communities.[25] This goal required Humana to establish new measures of success. To assess the impact and effectiveness of its DOH efforts, Humana started using the CDC's Healthy Days measure, a four-question, self-reported questionnaire where individuals assess the number of mentally and physically unhealthy days they had over the last 30 days. In 2020, Humana's Medicare Advantage (MA) members maintained overall QoL and improved their healthy physical days, even amid a global pandemic.[26] By tracking the impact of its DOH efforts on the outcomes that matter to individuals, Humana is able to target and iterate interventions to improve both individual and community QoL.

In our research, we also found that organizations effectively impacting DOH incorporate population health improvement measures into their executive compensation plans and board-reported success measures. One example of this approach is exemplified through Jefferson Health's former CEO, Dr. Stephen Klasko, who had 25% of his incentives based on addressing drivers of health in Philadelphia.[27] So that all organizations can learn from this approach, we encourage Jefferson Health to share the exact measures that were used to determine the impact of his efforts.

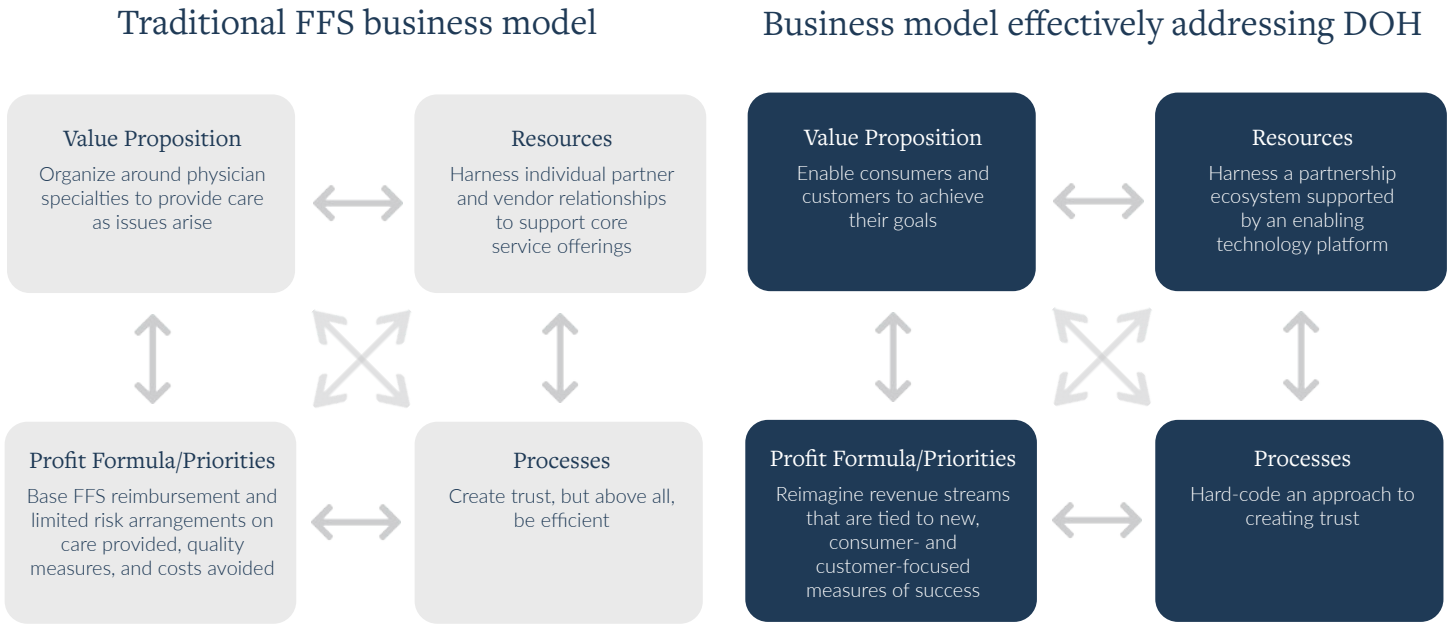
Based on these case studies—and those of other innovative organizations leading the way to effectively address DOH—we developed a business model compass to guide leaders as they design their approach to thrive.

TO TRANSFORM LIVES, TRANSFORM BUSINESS MODELS

An old business model can't deliver on a new value proposition. Applied to health care, that means leaders can't deliver health and keep people healthy with a business model built to address illness and sick care. So how might leaders transform their businesses? Much can be learned from the innovative approaches we studied and how they are meaningfully impacting DOH to improve health and life outcomes.

While there are similarities and themes across leading organization's models, we aren't suggesting there's one perfect model all organizations should employ. Yet, as leaders transform their businesses to embrace the health-focused approaches of the future, they should consider building models that incorporate the components outlined on the right side of Figure 4.

Figure 4: Comparing health care business models



Below, we dive into the details of this business model structure, highlighting similarities across organizations effectively addressing DOH, and discussing how organizations can create these capabilities and priorities. Notably, as demonstrated in Figure 4 and covered in discussion below, this new business model differs from those of traditional health care companies.

Value proposition: Enable consumers and customers to achieve their goals

The key value proposition insight that emerged from our research was that an organization must design around both customers' and consumers' desires for progress in order to meaningfully address DOH. Designing around both is required as the consumer is often not the paying customer. But incorporating both consumer and customer goals into service design is not the norm today.

Centuries ago, health care business models were organized around provider specialties, which resulted in a body system-specific approach that still permeates health care organizations today. A consumer's heart problem is referred to a cardiologist, and a lung problem is referred to a pulmonologist. If the consumer has both problems, then two doctors are needed. This mentality remains baked into today's business models, causing consumers to visit multiple doctors to address all of their ailments, each of which addresses the specific problems in a silo with limited information exchange.

Innovative organizations are filling the gap between what consumers and customers want, and what traditional organizations offer, and these models are multiplying and growing. In 2021, the for-profit DOH industry had 58 startups, $2.4 billion in funding, and a total valuation of over $18.5 billion.[28] This represents extreme growth since the passing of the ACA, given that 60% of these companies were founded after 2010, and a third after 2015.[29] Like the innovators we studied, these companies offer a fundamentally different value proposition.

Organizations that effectively address DOH to improve health and life outcomes look at the consumer's or patient's health holistically. They treat individuals as whole people, addressing physical health as well as nutrition, mental and emotional wellbeing, physical activity, spiritual health, and social connections. Leading organizations also design around the customer's or payer's pain points by partnering with them to understand what their struggles are and how a solution can be crafted to meet both their needs and those of the consumer.

Resources: Addressing drivers of health is a team sport

The size and complexity of today's DOH problem requires an ecosystem approach. Yet traditional companies and the industry ecosystem lack the organization required to execute it. As a result, most organizations focus on a single piece of the health puzzle.

For this disjointed technique to work, there must be clear interfaces and data interoperability between organizations—characteristics traditionally missing from the health care environment. As a result, traditional organizations don't have the clear, required interfaces with others to make a sizable impact on drivers of health. Instead, they are organized around partner and vendor relationships that support their core service offerings. This results in disparate, disconnected, and incomplete DOH efforts.

In our interviews, we uncovered a variety of resources required to successfully address DOH and improve individual lives. Paramount is the development of a partnership ecosystem that is supported by an enabling technology platform.

Leading organizations have amassed these ecosystems, creating a multiplayer, connected web to tackle the DOH problem. As discussed in the Good Sam case study, these ecosystems include players such as community-based organizations, startups, health systems, out-of-industry corporations, payers, and medical schools. Jefferson Health provides another example of how to amass this ecosystem. The health system is connected to Thomas Jefferson University, which houses both the Jefferson College of Population Health and the Sidney Kimmel Medical College. These colleges train the health workforce required for the future and future physicians. The organization also has extensive partnerships with community-based organizations to address DOH that it doesn't serve directly. Finally, Jefferson created the Philadelphia Collaborative for

Organizations that employ physicians, nurses, registered dieticians, health coaches, social workers, community health workers, etc., who work together in a symbiotic way, will be more successful in improving quality of life.

Health Equity to address health inequities and reduce health disparities in Philadelphia, which brings together community-based organizations like those addressing housing and healthy food needs, corporate partners, and its own health system resources.

Regardless of the type of company a leader runs or aspires to run, they can't tackle DOH and improve lives in a silo. As one executive we interviewed stated, "The only reason that we succeeded last year and will succeed again this year is because we've created a partnership ecosystem where we help each other."[30]

An enabling technology platform is critical to fuel interdependence across these partnerships. But, given the current disconnection between care and social service coordination platforms like UniteUs, Aunt Bertha, and NowPow, DOH efforts may remain disjointed until interoperability across platforms exists. (UniteUs acquired NowPow, but integration and transition from one platform to another can take years.)

Despite the external environment, innovators are taking an integrated data approach ***within*** their organizations. They are investing in the critical infrastructure required to know their consumers, understand their life situations, help them achieve their goals around DOH, and identify opportunities to address health disparities. This approach requires whole-person data (qualitative and quantitative) and a robust data and analytics function. Historically, organizations have only a piece of the data pie in the form of either claims or clinical data. Leaders in DOH incorporate whole-person data into their models, which includes claims and clinical data plus geographic information system (GIS) and consumer data.

Turning this data into action, multiple skill sets are required to treat the whole person. No one provider can help a person address all of their health-related DOH needs or goals. As a result, organizations that employ physicians, nurses, registered dieticians, health coaches, social workers, community health workers, etc., who work together in a symbiotic way, will be more successful in improving quality of life than traditional models that rely on physicians and nurses alone.

Drilling down further, the characteristics of care teams and leadership are also critical considerations when building a model to effectively address DOH. Humility and empathy are often considered soft skills in traditional models, yet when addressing DOH, they are indispensable. In our interviews, one executive at a large health system articulated the importance of these skills when engaging with community leaders: "We preface it by saying, 'We're listening. We want to understand. We think we know the priorities of the community, but are we sure? We're not. We need to validate the information in the data we're seeing with what you're seeing, feeling, and hearing because you have your finger on the pulse of this.'"[31] When seeking to create health, organizations must hire for empathy and humility, and then train their workforce in the tenets and applications of human-centered design to embed these characteristics into culture.

Processes: Hard-code an approach to create trust

In traditional FFS business models, processes are optimized for efficiency to support the profit model. But to effectively address DOH, building trusted relationships with patients, customers, and partner organizations is required. Patients with higher trust in their health care providers have higher quality of life, better health behaviors, and greater satisfaction with their health care treatments.[32]

In our interviews, leaders acknowledged the critical role of building trust with those they serve. But trust isn't built quickly. A 2021 report highlighted that 98% of internal medicine physicians agree spending appropriate time with patients is important for building trust, yet due to FFS incentives, this isn't the norm.[33] Additionally, a 2018 survey by the American Academy of Family Physicians (AAFP) revealed that while family physicians would like to discuss a patient's life circumstances, which they know drive health outcomes, 80% said they didn't have time. Another 64% said they weren't staffed to address risk factors even if they uncovered them.[34] Traditional primary care models incorporate a 15-minute visit as the norm, yet that's insufficient to create connections and build trust. Provider organizations that effectively address DOH lengthen the typical visit to 30-plus minutes; in some cases, visits are longer than an hour.

It's critical for organizations seeking to improve health and QoL to establish repeatable processes that create and sustain trusted relationships. This requires resources, skills, and dedicated time to do the following:

- Listen to consumers and customers;
- Uncover their struggles, pain points, and goals; and
- Iterate products and services based on these findings.

To understand an individual's goals, there must be an established process to ask questions, listen, understand, and act on the insights uncovered. These processes are not core to traditional health care business models. Many organizations are starting to ask questions about the social risk factors in people's lives, but those aren't necessarily the ***right*** questions. Asking if someone has a social risk is not equivalent to asking if they'd like help addressing it, or asking what progress they are really seeking.

In addition to patient-provider relationships, partnerships between organizations are more likely to be effective if based on trust.[35] In our interviews, leaders also emphasized the importance of listening to and establishing trust with their customers and community partners to identify their pain points and goals. This requires going into the community to meet with the leaders where they are most comfortable: in their own spaces. One executive highlighted the importance of this process in our interview: "We went to the communities, so we didn't sit in the offices and make a phone call

to a teacher....I hit the streets because...community health, equity work, and population health isn't from the office, just looking at numbers. You really have to get up to give those numbers and data and information, the full picture, the context."[36] DOH work can't be done alone, and trusted partners are required to execute it.

Profit formula and priorities: "Show me the incentive, and I will show you the outcome."[37]

In our interviews, we focused on the revenue side of the profit formula to uncover how organizations incentivized behavior to create health. The models most effective at addressing DOH to improve health and life outcomes are paid through value-based arrangements. For leaders we spoke to, this includes global capitation agreements or participating in payment models that entail both upside and downside risk.

Philanthropy is also a primary funding mechanism for these organizations, especially those in the early years of DOH efforts. Over 70% of organizations we interviewed cited private grants or philanthropic donations as a key funding source. Philanthropic funders are often more understanding that DOH efforts can take years to show a return, and often incentivize learning and innovation. Leaders embarking on DOH efforts should consider philanthropy as a bridge to a long-term funding model, leveraging philanthropic funds to learn which DOH efforts are most effective for their populations. In addition to philanthropy, leaders looking to diversify their funding sources also considered the many options provided by city, state, and national government entities.

Given the predominant FFS structure, industry-wide measures of success for DOH are unclear. As a result, most organizations are looking at process measures or relying on measures such as ROI that incentivize continued investment in traditional business offerings. In assessing leading organization's priorities, our research focused on the measures of success they used to determine if their DOH efforts were effective and impactful. We found the most important outcome measure to assess in DOH efforts is one that captures whether the individual achieves their desired progress. As discussed in the Humana case study, the CDC's Healthy Days measure is currently the best proxy.

In our interviews, many leaders also emphasized the importance of tracking lessons learned from their DOH efforts, and creating an evidence base in the process. When leaders mentioned this focus, they also noted their funder encouraged innovation, learning, and/or "smart failure," based upon hypothesis testing and iteration. Funders' priorities will drive the organization's priorities, and, therefore, leaders should choose their funding sources accordingly.

Additionally, executives and leaders prioritize the measures of success reported to the board of directors. If the organization's goal is to improve individual- and population-level QoL in a sustainable way, measures that incentivize behavior to achieve those goals, such as Healthy Days or improvement in population life expectancy, should be reported to the board of directors and included as part of executive incentive plans. Lastly, measures that disincentivize that behavior, such as near-term ROI of DOH efforts, should be avoided.[38]

Transformation is a journey, and this set of business model characteristics offers guidance for leaders to consider as they craft their future businesses. Establishing new business models that incorporate these components represents a critical step toward a thriving future—for organizations and those they serve.

The models most effective at addressing drivers of health to improve health and life outcomes are paid through value-based arrangements. This includes global capitation agreements or participating in payment models that entail both upside and downside risk.

CONCLUSION

The pressure to effectively address DOH and prepare for a value-based environment is mounting. Unfortunately, today's traditional FFS business models aren't up for the challenge. As leaders increasingly find themselves in an environment characterized by evolving financial uncertainty, they need a transition plan to remain financially viable and continue to serve their communities. The business model compass offered here is foundational to that plan.

In future research and work, we'll delve into specifics around ***how*** leaders can transform their business models to mirror those of organizations effectively addressing DOH and do so in a financially sustainable way. To enhance business model guidance and insights shared in this paper, additional research could also address the following:

1. What specific steps should leaders follow as they implement these business model suggestions to effectively transform their businesses from FFS-dominated organizations to those organized around addressing DOH?
2. Which specific measures of success should boards or governing bodies put in place to incentivize prioritization of and investment in DOH?
3. What progress do consumers and customers seek that leads them to choose an organization that effectively addresses DOH?

There is a pathway out of today's fee-for-service, sick care models, and it starts with creating business models that support addressing drivers of health. Focusing on what matters to consumers and customers, establishing payment models to support addressing those needs, measuring whether consumer and customer goals are achieved, and connecting dots across the disconnected ecosystem are foundational steps on this journey. Helen Keller perhaps said it best when she noted, "Alone we can do so little. Together we can do so much."[39]

NOTES

1. "Why does healthcare cost so much?" (web page), BlueCross BlueShield, accessed April 19, 2022, https://www.bcbs.com/issues-indepth/why-does-healthcare-cost-so-much.

2. Sanne Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," NAM Perspectives, National Academy of Medicine, https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

3. Eric C. Schneider et al., "Mirror, Mirror 2021: Reflecting Poorly," The Commonwealth Fund, August 2021, https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly.

4. Magnan, "Social Determinants."

5. "Medicaid's Role in Addressing Social Determinants of Health," Robert Wood Johnson Foundation, accessed April 20, 2022, https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html.

6. Matthew W. Kreuter et al., "Addressing Social Needs in Health Care Settings: Evidence, Challenges, and Opportunities for Public Health," Annual Review of Public Health 42, no.1 (2021), https://www.annualreviews.org/doi/10.1146/annurev-publhealth-090419-102204.

7. Schneider, "Mirror, Mirror."

8. "Like Magic? ('Every system is perfectly designed…')" (web page), Institute for Healthcare Improvement, August 21, 2015, http://www.ihi.org/communities/blogs/origin-of-every-system-is-perfectly-designed-quote.

9. Kulleni Gebreyes et al., "Addressing the Drivers of Health," Deloitte Insights, November 5, 2021, https://www2.deloitte.com/us/en/insights/industry/health-care/drivers-of-health-equity-survey.html.

10. Gebreyes, "Addressing the Drivers."

11. In health care, the consumer, also known as the patient or member, is often not the paying customer. Instead, the customer who pays the majority of the bill is a public or private insurer or an employer. In traditional health care models, providers treat consumers in exchange for reimbursement from these customers. The exception is for uninsured patients, in which case they are both the consumer and the customer.

12. See "Factor Health" (web page), accessed April 20, 2022, https://sites.utexas.edu/factorhealth/.

13. Maninder K. Kahlon et al., "Effect of Layperson-Delivered, Empathy-Focused Program of Telephone Calls on Loneliness, Depression, and Anxiety Among Adults During the COVID-19 Pandemic," JAMA Psychiatry 72, no. 6 (2021), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2776786.

14. Kahlon, "Effect of Layperson."

15. Sara Berg, "Empathetic Phone Calls Reduce Loneliness, Depression in Older Adults," American Medical Association, May 28, 2021, https://www.ama-assn.org/delivering-care/population-care/empathetic-phone-calls-reduce-loneliness-depression-older-adults.

16. Kahlon, "Effect of Layperson."

17. Mike Pykosz, interview with Steve Krause and Trevor Price, "A Healthy Dose" podcast, April 29, 2021, https://soundcloud.com/ahealthydose/mike-pykosz.

18. "Oak Street Health Opens New Center in Chicago," Oak Street Health press release, December 1, 2021, https://www.oakstreethealth.com/news/oak-street-health-opens-new-center-in-chicago.

19. "2019 Updates in Primary Care Consumer Preferences: 11 Surprising Results from Our New Primary Care Consumer Survey," Advisory Board, 2019, https://www.advisory.com/-/media/Project/AdvisoryBoard/shared/Research/MIC/Executive-Research-Briefings/2019/2019-Updates-in-Primary-Care-Consumer-Preferences_MIC.pdf.

20. "An important message from Chief Medical Officer, Dr. Griffin Myers," Oak Street Health, accessed April 25, 2022, https://www.oakstreethealth.com/letter-to-patient.

21. Breanna Lathrop, COO at Good Samaritan, in discussion with the author, October 2021.

22. Lathrop, discussion.

23. Lathrop, discussion.

24. Lathrop, discussion.

25. "2021 Bold Goal Progress Report," Humana, accessed April 22, 2022, https://populationhealth.humana.com/2021-bold-goal-progress-report/.

26. "2021 Bold Goal Progress Report: 2020 Results," Humana, June 2021, https://populationhealth.humana.com/wp-content/uploads/2021/06/Humana_BG_progress_2021_digital_v1.8.pdf.

27. Molly Gamble, "Jefferson Has One More Reason to Call Itself a Population Health Powerhouse," Becker's Hospital Review, June 25, 2018, https://www.beckershospitalreview.com/care-coordination/jefferson-has-one-more-reason-to-call-itself-a-population-health-powerhouse.html.

28. Zachary N. Goldberg and David B. Nash, "For Profit, but Socially Determined: The Rise of the SDOH Industry," Population Health Management, October 14, 2021.

29. Goldberg and Nash, "For Profit."

30. Senior Vice President of Community and Population Health at a large health system in the United States, in discussion with the author, January 2022.

31. Senior Vice President, discussion.

32. Johanna Birkhäuer et al., "Trust in the Health Care Professional and Health Outcome: A Meta-Analysis," PLoS One 12, no. 2 (February 7, 2017), https://pubmed.ncbi.nlm.nih.gov/28170443/.

33. "Surveys of Trust in the U.S. Health Care System," ABIM Foundation, May 21, 2021, https://www.norc.org/PDFs/ABIM%20Foundation/20210520_NORC_ABIM_Foundation_Trust%20in%20Healthcare_Part%201.pdf.

34. "Social Determinants of Health (SdoH): Family Physicians' Role," American Academy of Family Physicians, 2017, https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf.

35. Jeanne Brett and Tyree Mitchell, "Research: How to Build Trust with Business Partners from Other Cultures," Harvard Business Review, January 31, 2020, https://hbr.org/2020/01/research-how-to-build-trust-with-business-partners-from-other-cultures.

36. Senior Vice President, discussion.

37. Scott Phillips, "'Show Me the Incentive and I Will Show You the Outcome,'" The Sydney Morning Herald, May 19, 2018, https://www.smh.com.au/money/banking/show-me-the-incentive-and-i-will-show-you-the-outcome-20180518-p4zg6g.html.

38. Before measuring ROI, leaders should stop to ask if this measure will incentivize the behavior they are seeking to create. If they are testing an unproven intervention that may take years or decades to demonstrate a return, using ROI as the primary measure of success will not yield their desired results.

39. "Alone We Can Do So Little. Together We Can Do So Much," Quote Investigator, April 21, 2014, https://quoteinvestigator.com/2014/04/21/together/.

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