Dr. Cagle Leads Cone Health's 5-in-5 Moonshot to Increase Life Expectancy by Five Years
TRANSCRIPT

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[00:00:30] Announcer: Welcome to A&M Healthcare Industry Group's, *What's Your Moonshot?* Podcast Series, where world-class healthcare leaders seek to solve big problems. Listen, as we talk to today's health system CEOs about the journey to achieve their moonshots.

[00:00:47] Stu: Welcome to A&M's *What's Your Moonshot?* Podcast. I'm Stu McClean, a managing director in Alvarez & Marsal Healthcare Industry Group. I'm joined by my co-host, Dr. David Shulkin, the ninth secretary of the US Department of Veterans Affairs. Today we are delighted to welcome Dr. Mary Jo Cagle, the President and Chief Executive Officer of Cone Health. Mary Jo is the first woman and the first physician to lead this multi-hospital system.

Since joining the organization in 2011, she's been instrumental in leading Cone Health to national recognition for quality of care. Dr. Cagle earned her medical degree from the University of Alabama School of Medicine in Birmingham, completed her residency in OB-GYN at Greenville Hospital System in Greenville, South Carolina. She also completed her chief medical fellowship through the Health Management Academy. She was named to Modern Healthcare's list of 50 most influential clinical executives in 2023. Congratulations, and we are excited to have you on the podcast today.

[00:01:55] David: Thank you. It's good to see you this morning.

[00:01:58] Stu: That's great. Let's jump right in. Your system has large reach across North Carolina, and I recognize that you are focused on providing care, access, and instilling a healthy lifestyle for as many people as you can. Can you share some details about your moonshot, your five-in-five effort to add five years of life for the people in the communities that Cone Health serves?

[00:02:23] Mary: Absolutely. Like many health systems, we really have been looking at our data to understand how to help our community. One of the things we recognized was that the thing that affects longevity more than your genetic code is your zip code, and that was astounding to us. What we found, for instance, is that when we looked at our main flagship hospital, Moses Cone Memorial Hospital, that if you went five miles north of that hospital, your longevity would be 85 years. If you went five miles south, the longevity is 70 years, a 15-year difference only based on your zip code. That was amazing to us.

As we looked throughout the five-county area that we served, we found those pockets all over the area that we serve. That's not acceptable to us. We talked to our doctors, our

caregivers, and they couldn't see a difference in what they were doing. It wasn't apparent to them. Yet we had these astounding differences in result. That's not acceptable to us, and it's not acceptable to the people who lead in our community. We're setting about to change that, and that's our moonshot.

[00:03:51] David: I think it's really remarkable. I think it's what not-for-profit health systems should be serving their community like this, and that's very, very meaningful. It actually comes at a time that I'm sure you know this, that for the first time in decades, the life expectancy in the United States has actually dropped from 77 years to 76.1 years. In the last couple years, it's dropped. These types of initiatives and addressing it is really important. What specifically are you thinking about implementing? What are the ways that you think that you can actually help improve longevity?

[00:04:36] Mary: There are four things, big general things that we're doing. We know that we've got to look at delivering holistic treatment for upstream prevention of chronic disease. We have to provide healthcare that's available, accessible, and affordable. We've got to promote health healthy living conditions by looking at the social determinants of health, and we've got to eliminate bias and discrimination so we can build trust with our consumers.

More specifically, there are five areas that we as the health system can be responsible for. We're going to look at cardiometabolic disease. We're going to look at cancer. We're going to look at infant and maternal mortality, opioid overdose, and homicides specifically from gun violence. Those are the five disease states we're going to look at over the next five years. More than that, we're going to be a convener of community agencies and partnerships to really look at those social determinants of health, because we know that disease is 20% of the outcomes, but social determinants of health are 80% of the outcomes that affect longevity.

[00:05:49] David: Yes. Mary Jo, I think it's really terrific that you're being that specific about the conditions that you're targeting, and these are huge issues in the community with fortunately, some of them are really addressable, but it seems to me that there's this overlay between behavioral health and physical health in so many of these. Are you thinking about approaching this in a more integrated way?

[00:06:19] Mary: I'm glad you mentioned that David. Even pre-pandemic, we had started processes to integrate behavioral health into all of our primary care. Even some of our-- Well, we consider obstetrics and pediatrics primary care for us as well, so we have integrated behavioral health working with our psychiatrist and our psychologist in the practice into all of our primary care.

If you walk into any of our family practice or internal medicine practice, you will see that there's behavioral health there, some with a real-life person and some with virtual behavioral health. In our pediatric offices, we've integrated behavioral health as well as in our obstetric practices. We're not eliminating, we're not saying that that's not important. It is an integrated part of the things that we're doing. Absolutely. I'm glad you mentioned that. That is an integrated part, and we believe there has to be wraparound services that addresses the whole person. That's the holistic care that I was referring to.

[00:07:37] Stu: Thanks so much, Dr. Cagle. This focus right in this program just seems so powerful over time, and you have a particular footprint, right? Can you talk a little bit about the unique challenges around the rural element of your delivery system?

[00:07:56] Mary: I would say it's a diverse delivery system over five counties. Greensboro itself has a very urban center. Of course, they're the suburbs, but then the other counties that we have, Rockingham County is extremely rural and agricultural. Other counties that we

serve also, Randolph County, it can be very agricultural. Then Alamance County is one of those mixed counties where you'll, in one area, it seems very rural, and then you go to the city that's there and it is bustling and busy.

We have to have the capabilities to serve all of those communities. Our strategy has to be one that we have mobile clinics that are able to go into those rural areas. That's why our partnerships are so critical. Our partnerships are with the city. They're with the county governance, but they're also with the builders association, with congregational nursing, with food banks.

It is that we have 73 different partnerships that we've already created with our Center for Health Equity of people who want to make a difference, and we are looking to say, "Okay, this is the kind of coalition we need for rural healthcare, and this is the coalition that we're going to put together for the urban care." Because they are different and they each present different challenges.

In fact, tomorrow we have, in Rockingham County, we're partnering with UNC and Chapel Hill to do a symposium on rural healthcare, because the challenges of each are quite unique. In fact, in our area, we have to provide translation for 112 languages. Across our area for which we are accountable, we have to have great flexibility and the ability to think about, in this area, the needs are this, and in this area, we have to be able to deliver care in a different way. While we need flexibility in our delivery systems, I would tell you those five priorities that I mentioned earlier are the same. The same disease processes, but flexibility and how you address the problem is what we must have.

[00:10:31] David: It's really impressive all this outreach and partnership in the community to impact the social determinants. What's been the reaction from the community and how do you know if you're connecting with the community?

[00:10:46] Mary: This is the most exciting part to me, is that we've had such an outpouring from the community. Our first event in Greensboro was on July the 8th. We had, as I mentioned, 73 partners that showed up. I should have checked yesterday with our Center for Health Equity because my partnership number might be higher by now because the requests keep coming in to partner.

At that event, we had 800 people who showed up. A few statistics, let me just tell you, and then I'm going to share a story which is most powerful of all. We gave away over 11,150 pounds of food. We provided 1000 meals. There was a gentleman who visited our hub who was homeless and had not had a meal for two days. We were able to give him a meal and provide him food for the next two days as well as do a medical screening for him. It made a big difference for him.

There was another elderly gentleman, his children brought him to our medical screening. He was hypotensive, his blood pressure was low, and our team was worried about him. We were able to get him to our urgent care who felt like he needed to be admitted to the hospital. We were able to admit him, he was hospitalized for about 48 hours. We heard back from his children thanking us, they said, "We think you saved our father's life for being there that day."

On that day, we also had our mobile mammography clinic there, we had positive screenings, and we've been able to get women in for biopsies who we don't know how long they might have gone without having mammograms and how long things might have progressed had they not had that screening. The engagement and the thank you cards that we've gotten from people in that community has been tremendous. We did exercise, fun dancing exercise

classes in the parking lot. We keep hearing from them, "Please come back soon to the community." The engagement has been great.

I'll tell you the other great story of what difference we've made. We started a year ago just with a simple project to have equity and how we manage hypertension. We found that we had 5% difference in hypertension control between Caucasian and African American patients. In one year, we've been able to get that within 1% and we started with our Caucasian patients at a 70% control. Everybody is up, the total number is up to 75% which means Caucasians are at a 5% better control rate, and now African Americans are up at 74. They were lagging by 5, now they're only lagging by 1, that's a huge improvement in African-American control. Everybody improved and we've gotten near equity. This work improves everyone's care. That's the exciting thing that we're seeing.

[00:14:29] Stu: Yes, it's very exciting. I thought this was going to be a harder question, but I think you're a step ahead. At A&M, we just love to measure progress, right? You've touched upon, just the ability to close the gap on that racial distinction and then raise the bar for everybody. How are you measuring comprehensively the progress here?

[00:14:51] Mary: I think what we're really good at is doing the medical measurements. Those were, of course, the first measurements that people came up with, measuring blood pressure, measuring hemoglobin A1Cs. Those were the easy things for our teams to come up with. The more important things to think about were the social determinants of health. Consumer touches. We really turn to our partners like the United Way, and others to say, "What are the other important things that we should be measuring?" When we talked about food insecurity, can we start measuring how many people are having regular meals, children with regular meals? How many people have we connected to a primary care physician, and the increase in the number of people with primary care physicians, say safe housing improvements?

I would tell you, those measurements are not yet as robust as they need to be. We're partnering with our community members to strengthen those measures because as we started the conversation saying social determinants of health have 80% of the influence on these long-term outcomes and we have to get as good at measuring those as we are at measuring these medical things, that those of us in health care have been taught to measure so well.

[00:16:33] David: Mary Jo, I know that people listening to the podcast are admiring your vision and your leadership. I also probably know that there are some people who are saying, "Well, things must be really good in North Carolina, not where I'm from. I'm struggling to meet my payrolls, I'm fighting with the payers, I'm dealing with workforce shortages." How can they afford to be focused on these types of outward activities when so much is struggling in the home organization? I just wonder what lessons you may have had for others that might aspire to be doing the things you're doing but saying, "Boy, it's just financially just too tough to take on."

[00:17:28] Mary: I would tell you, we've had all of those same issues right here at Cone Health. I will say, doing this work has been a great antidote to burnout for the people on our team. To do something that calls back to the reason of why we chose to do health care in the first place, to go back to service of others in an environment where there is gratitude, and great appreciation when you come and when you go to the people and listen rather than taking and being paternalistic and saying, "We have all the answers for you." Returning to that level of service is a great antidote for all the burnout we've all experienced over the past three years, so I offer that first.

Secondly, I want to emphasize again, we're not trying to do it all ourselves. We're being a convener of a great group of partners. Third, let me talk about how we are staffing this. We started with, we can't afford a bunch of new FTEs. We started with saying, "Who has a bunch of passion for this work? Can we do partial FTEs?" We started with doing this with partial FTEs and allowing people in different parts of organizations to do this with .5, .4 FTEs as we grew this, and then we began to apply for grants. We've been successful in that in the state, at the state level, on the federal level, and then through philanthropy. That's how we have funded a great deal of this work.

As that has grown and as we through the same work, everybody around the country has done really disciplined work to get our financial house back in order, and as we're now back in the black because of the same hard work all of my colleagues around the country are doing, we're able to put more finances into this. I will say, we've got parts of our enterprise that are in more affluent neighborhoods that are having bigger margins and those margins get to fund this work. That's very intentional. I believe in the aphorism that we all say no margin, no mission. Well, when we get a margin, it gets to fund our mission. This is our mission to serve this part of our community and we're very intentional about that. That's what I would say. I mean, it is done from a place of calling. Those of us in nursing and in medicine, who know that is our calling to do this work, it fills our cup to go out and do this work.

[00:20:34] Stu: Thank you so much, Dr. Cagle. It's a great way to finish that in order for you to be successful, you really have an opportunity and an obligation to harness the passion of your team. That just feels so powerful. I'm really struck by we focus so much on ideas becoming implementation. I'm struck by your approach, the general becomes the specific. Then the measurement and the harnessing of the team makes me feel really confident about the success that you're already having and will continue to have. We look forward to touching base along the way to see how well this continues to go. Thank you.

[00:21:15] Mary: I'd love to talk to you in five years.

[00:21:18] David: Great. Well, thank you again for spending time with us today.

[00:21:21] Mary: Thank you.

[00:21:21] David: We really appreciate it. Thank you.

[00:21:23] Mary: Great

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[00:21:33] Announcer: Alvarez & Marsal, Leadership. Action. Results.

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[00:21:50] David: I thought that was terrific. You could really sense the real mission. I thought her comment that this is the anecdote to burnout probably really really was true.

[00:22:03] Stu: That is cool. I didn't see that comment. That was a really cool element.

[00:22:11] David: I think people always like to feel part of doing something good. The other thing I liked about her moonshot is that it's really one that she has a lot of opportunity to continue to make progress on with the average lifespan being around 77 now. I was doing some research the longest-living human was Jean Talbert, who died in France in 1997, at age 122. We've got a long way of possibility to expand longevity.

[00:22:58] David: Today, there are 90,000 Americans over 100. I think that for so long, we've been making progress, extending and expanding longevity but with the reasons why Mary Jo listed, especially things like the opioid overdose and now fentanyl, all the things that young people die from as well, lifespan's actually going down. Not up.

[00:23:32] Stu: Powerful. Thank you, David.

[00:23:36] [END OF AUDIO]