



[Robina Foundation](#)

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**ROBINA FOUNDATION**  
**ANNUAL MEETING**

**AUGUST 26-27, 2008**

**Minneapolis, Minnesota**

*Presented to the  
Board on Aug 27,  
2008.*

## **Care Guides in the Primary**

Developing and testing an efficient, sustainable  
chronic disease outcomes

**Richard Adair, MD**  
Principal Investigator

**Penny Wheeler, MD**  
Executive Sponsor

A proposal for innovation presented to the Robina Foundation Board  
August 27, 2008



COMMON PURPOSE  
UNCOMMON CARING



*Do NOT Remove*

## **A True Story: David B. is a 67-year old man with a chronic heart condition...**

- Hospitalized multiple times
- After a recent discharge, he was enjoying a life free of symptoms thanks to effective medications
- At a routine exam with his cardiologist, he was instructed to take a new medication, one that was more expensive
- He received a free, 30-day supply of the new medication
- Several months later, he experiences a relapse in the form of a florid case of congestive heart failure and is hospitalized

**What went wrong??**



COMMON PURPOSE  
UNCOMMON CARING

**The U.S. healthcare system is plagued by  
fragmented and uncoordinated care.**

**Patients with complex, chronic illness are  
particularly vulnerable.**



COMMON PURPOSE  
UNCOMMON CARING

**Chronic disease is rampant and inadequately  
managed, and there are significant human and  
financial costs...**

**Heart failure:**

- PREVALENCE: 5 million Americans; COST: \$40 billion
- 1/3 of heart failure patients die within one year and 6-month all-cause readmission rates are 40%

**Diabetes:**

- PREVALENCE: 24 million Americans; COST: \$100 billion
- Only 14% achieve optimal care goals in Minnesota with a 20% increase in diabetic-related death as a result

**Hypertension:**

- PREVALENCE: 50 million Americans; COST: \$50 billion
- Only 34% achieve BP goal; untreated HTN increases the incidence of stroke by 25%



COMMON PURPOSE  
UNCOMMON CARING



## Clear guidelines exist for treatment and the prevention of secondary complications, but:

### System Barriers

- Poor communication between providers
- Physicians lack time during office visits
- No reimbursement for coordination activities

### Patient Barriers

- Lack of knowledge
- Cost
- Logistical challenges (e.g. language)
- Psychosocial barriers



COMMON PURPOSE  
UNCOMMON CARING

## Why have care coordination efforts failed?

- Reimbursement system not currently supportive
- Too costly to bring to a larger scale
  - Workforce issues
  - Financial constraints
- Patients have traditionally played a passive rather than active role in health care
- Current “care management” activities primarily from payers and divorced from primary care relationships



COMMON PURPOSE  
UNCOMMON CARING

## Key Principles of Our Approach

- Study common diseases for which early treatment is known to prevent stroke, heart attack, and kidney failure
- Design an intervention which is widely and easily exportable
- Study a large enough sample size and clear quantitative outcomes so statistical analyses are robust
- Focus on value = outcomes / cost



COMMON PURPOSE  
UNCOMMON CARING

## Relationship to Published Work

- Guiding framework is Wagner's Chronic Care Model
- Employs much of Bodenheimer's 'teamlet' model in a targeted way – focusing on chronic conditions
- Appreciates evidence that treatment is effective in long-term disease management



COMMON PURPOSE  
UNCOMMON CARING

## Testing a New Care Model

**SPECIFIC AIM:** To increase physician and patient adherence to established clinical care guidelines for diabetes, hypertension, and heart failure.

**THE APPROACH:** Effectively coordinate care from the primary care office and empower patients to self-care using:

- Care Guide
- Care Contract
- Care Team



COMMON PURPOSE  
UNCOMMON CARING

## The Care Guide Concept

- New type of employee in the primary care clinic
- Assigned to patients with chronic disease
- Not clinically trained; will not provide medical advice
- Will play a key role in educating and supporting patients
  - best practice guidelines
  - resources and referrals
  - self-care skills
  - barrier resolution
- Provides a familiar, consistent, trusted point-of-contact
- Will keep the care team focused and unified



COMMON PURPOSE  
UNCOMMON CARING

## Care Guide Activities

- Regular contact with patients
  - reviewing goals and progress
  - agenda setting for appointments with physician
  - confirmation of patient knowledge
  - facilitating timely treatment action
  - barrier identification
- Involved in the inpatient experience by visiting patients prior to discharge
- Facilitating communication between providers; ensuring visibility of the electronically shared care contract



COMMON PURPOSE  
UNCOMMON CARING

## Portrait of a Care Guide

### KEY PERSONAL ATTRIBUTES

- Friendly, energetic, self-confident, fast learner
- Astute awareness of human nature and environmental forces
- Understands the limits of the role
- Does not encourage or enable dependency
- Appreciates the subtle distinction between being persistent and being a pest
- Collaborative
- Culturally sensitive



COMMON PURPOSE  
UNCOMMON CARING

## Care Guide Training

They possess basic skills...

- College level coursework
- Bilingual
- Proficiency with computers
- Interest in healthcare
- Able to commit for at least one year

... then we provide additional training

- Overview of primary care
- Medical and legal aspects of the role
- Resource and referral mechanisms
- Techniques for motivating patients
- Communications
- Excellian (electronic medical record)



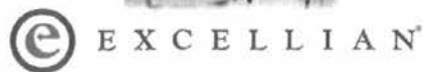
COMMON PURPOSE  
UNCOMMON CARING

## An Electronic Care Contract

- Will reside in Allina's system-wide EMR
- Marriage of behavioral contracting and shared care
- Two key elements:
  - Declarative contract language and signatures
  - Summary of progress towards goals
- Tangible testimonial
- Positive reinforcement
- Printable and portable
- Functionality already exists



COMMON PURPOSE  
UNCOMMON CARING



## A Sample Care Contract

### My Promise to Take Care of My Diabetes

- I will have a care guide to work with me, free of charge (funded by a research grant).
- I will learn what national leaders call "best practice" goals for my diabetes.
- I will ask one family member or friend to be on my care team.
- My care guide, my doctor, my family member (or friend), and myself will work together to achieve "best practice" goals for diabetes.
- I will be honest and ask for help when I need it. (For example, if my medications are too expensive.)
- My care team and I will regularly review my progress towards "best practice" goals.
- I agree to carry this contract with me and show it to all doctors and other care providers who treat me.

\_\_\_\_\_  
Patient Signature & Date

\_\_\_\_\_  
Care Guide Signature & Date



COMMON PURPOSE  
UNCOMMON CARING

\_\_\_\_\_  
Physician Signature & Date

## A Sample Care Contract

### My Progress Towards 8 "Best Practice" Diabetes Goals

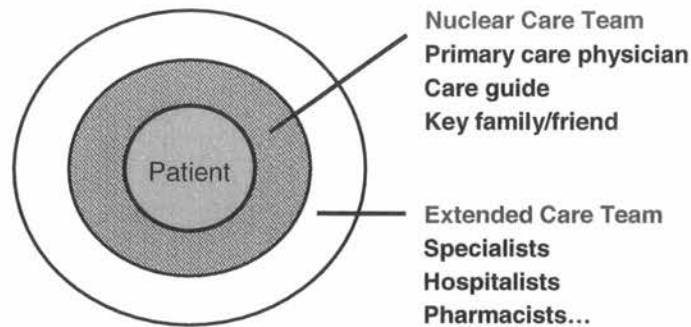
|                                                               | Not Achieved<br>(0)                 | Achieved<br>(1)                     |
|---------------------------------------------------------------|-------------------------------------|-------------------------------------|
| Not smoking                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Using aspirin regularly                                       | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| HbA1c < 7.0% at most recent measurement                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Blood pressure < 130/80 at most recent measurement            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Funduscopy (eye) examination within the last year             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Measurement of urinary albumin excretion within the last year | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| If abnormal albuminuria, taking ACE or ARB                    | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| LDL cholesterol < 100 at most recent measurement              | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Goal Total =                                                  |                                     | <input checked="" type="checkbox"/> |

↑  
Primary Outcome



COMMON PURPOSE  
UNCOMMON CARING

## The Care Team



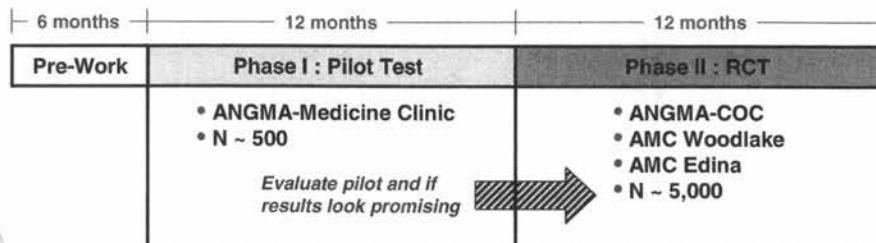
The care contract will be the central underpinning for:

- Inter-provider communication
- Goal alignment



COMMON PURPOSE  
UNCOMMON CARING

## Overview of Study Design



- ✓ Test our ability to execute
- ✓ Course corrections / refinement

- ✓ Study guide-patient ratio
- ✓ Optimal characteristics of guides
- ✓ Complex vs. non-complex patients



COMMON PURPOSE  
UNCOMMON CARING

## What will we measure?

### PRIMARY OUTCOME:

- Change in the absolute number of clinical benchmarks attained

For example, Mr. Jones met 3 of the 8 diabetes guidelines at baseline. After working with a care guide for 12 months, he now meets 7 of 8.

### SECONDARY OUTCOMES:

- Actual and estimated cost data
- Patient and provider experience
- Patient characteristics (e.g. psychosocial factors, demographics)



COMMON PURPOSE  
UNCOMMON CARING

## Intervention Sites

### Primary Care Clinics

- ANGMA Medicine Clinic *Pilot (inner city)*
- Allina Medical Clinic Woodlake *RCT (inner ring suburb)*
- Allina Medical Clinic Edina *RCT (suburb)*
- ANGMA Center for Outpatient Care *RCT (suburb)*

### Abbott Northwestern Hospital

- Acute care facility servicing the above clinics
- Extensive resources, including Institute for Health & Healing

- ✓ diverse socioeconomic representation
- ✓ integrated EMR across all sites



COMMON PURPOSE  
UNCOMMON CARING



## Why start with ANMGA Medicine Clinic?

- Diverse patient population, including new immigrants
- Strong tradition of research and education
- Enthusiastic and idealistic young physicians who will shape the future
- Continuity clinic for Abbott Northwestern & University of Minnesota internal medicine residency programs
- Extensive experience with EMR – Excellian links the clinic to ANW
- Daily presence of the Principal Investigator



ALLINA  
Hospitals & Clinics

COMMON PURPOSE  
UNCOMMON CARING

## Project Oversight and Support

- Principal Investigator and site physician leads
  - Primary care physicians “in the trenches”
- Patient and Family Advisory Council
  - 10-20 patients (and family) to provide feedback and input
- Robina Project Advisory Board
  - Operational and capital issues; strategy and direction
  - Representative body for extended care team members
- Evaluation Team
  - Health economists and experts in organizational redesign; prominent U of MN faculty
- Institute for Health and Healing
  - Care guide support for behavioral coaching and lifestyle management referrals
- Allina System Support
  - Center for Healthcare Innovation; Quality Measurement unit
  - Excellian Team and Clinical Decision Support



ALLINA  
Hospitals & Clinics

COMMON PURPOSE  
UNCOMMON CARING

## Innovative Aspects of the Design

- Patient needs matched by care guide support
- Placing non-clinically trained care guides in the primary care office
- Electronic care contract
- Involving a key family member or friend in the care team
- Robust methodology: pilot and RCT



COMMON PURPOSE  
UNCOMMON CARING

## Potential Pitfalls

- Care guides may require a clinical background to be effective, and require a higher salary than we propose
- Clinic staff might reject the model; too much too soon
- Care guides may tend to be more transient than we expect
- Patient enrollment may be less than we predict
- Selection bias and the Hawthorne effect

**The project team is committed to  
stewardship of the grant.**



COMMON PURPOSE  
UNCOMMON CARING

## Future Direction

- As the pilot and Phase II are successful, we anticipate future submissions to continue the work:

Phase III – expand care model across Allina

- Additional providers (e.g. pediatrics)
- Additional conditions (e.g. asthma, depression)
- Additional methods (e.g. home-monitoring)

Phase IV – expand beyond Allina

- Invite payers, and potentially other Robina grant recipients, to partner with us in thinking about public policy changes and payment reform in light of findings
- We will continue to respond to the evolution of health information technology
  - Maturation of the electronic personal health record
  - Development of web-based personal health records



COMMON PURPOSE  
UNCOMMON CARING

## Another True Story: Esther D. is a 78-year old woman with diabetic nephropathy...

- Takes an ACE inhibitor to stabilize kidney function
- Admitted to ANW with a broken hip
- Nephrologist discontinues her ACE inhibitor while she is recovering as an inpatient
- Upon discharge, no one instructs her to restart ACE inhibitor
- She is instructed to follow-up with her nephrologist after discharge, but fails to show for the appointment
- 6 months later, an ANGMA primary care physician discovers abnormal kidney function requiring treatment

**Could the care model we propose have changed her experience?**



COMMON PURPOSE  
UNCOMMON CARING

## We believe the answer is YES.

- Care guide would have been involved in the discharge process
- Care contract would have been shared electronically and in print
- Patient's son would be an engaged member of the care team



COMMON PURPOSE  
UNCOMMON CARING

## Project Impact

- Improve the quality of life for patients with chronic illness
- Provide a model of primary care practice that makes it an attractive career option
- Advance the blueprint for a scalable "medical home"
- Partner with payers and public policy experts in healthcare redesign



COMMON PURPOSE  
UNCOMMON CARING

## **Transforming the U.S. Healthcare System**

- **Patient outcomes**
- **Cost**
- **Primary care**



COMMON PURPOSE  
UNCOMMON CARING

## **Robina Foundation Board of Directors Annual Meeting**

**August 26, 2008**

## Faegre and Benson Office

**2200 Wells Fargo Center, 90 South 7<sup>th</sup> Street, Minneapolis, MN 55402, Phone: 612-766-8078**  
**(Go to 22<sup>nd</sup> floor and receptionist will direct you to the room.)**

**August 27, 2008**

**Robina Foundation Office (4900 IDS Center, 80 South 8<sup>th</sup> Street)**

[illegible]

**ROBINA FOUNDATION BOARD OF DIRECTORS MEETING**

**August 25-27, 2008**

**MONDAY, AUGUST 25**

6:00 p.m. Dinner at Vincent's, 1100 Nicollet Mall, Minneapolis, MN 55403  
Phone: 612-630-1189

Lodging: Peter Karoff and Steve Schroeder at the Marquette Hotel

**TUESDAY, AUGUST 26**

8:00 a.m. Board of Directors Meeting at Faegre and Benson – see Agenda

12:00 Noon Lunch in meeting Room

1:00 p.m. University of Minnesota Law School – Dean Wippman

5:30 p.m. Peter and Steve to ride with Nancy to Crosby's home  
(Unless you have a better offer!!)

6:00 p.m. Dinner at Tom Crosby's home (Spouse – Ellie)  
1612 Willow Drive, Long Lake, MN 55356  
Phone: 763-473-1141

8:30 p.m. (approx) Karoff and Schroeder back to hotel via limo service  
(Jim Pyle – 952-470-0551)

Lodging: Karoff and Schroeder at the Marquette Hotel

**WEDNESDAY, AUGUST 27**

8:00 a.m. Abbott NW – Wheeler, Adair, Britt – Robina office – see Agenda

Noon Adjournment

|           |                                       |
|-----------|---------------------------------------|
| <b>1</b>  | MINUTES                               |
| <b>2</b>  | GOVERNANCE                            |
| <b>3</b>  | PRESIDENT'S REPORT                    |
| <b>4</b>  | COMMITTEE REPORT<br>FINANCE           |
| <b>5</b>  | COMMITTEE REPORT<br>GRANTS PROGRAM    |
| <b>6</b>  | COMMITTEE REPORT<br>AUDIT             |
| <b>7</b>  | COMMITTEE REPORT<br>LEGAL             |
| <b>8</b>  | FUTURE BOARD MEETINGS                 |
| <b>9</b>  | UNIVERSITY OF<br>MINNESOTA LAW SCHOOL |
| <b>10</b> | ABBOTT NORTHWESTERN                   |





**Robina Foundation  
Meeting Minutes  
May 20, 2008**

***DRAFT***

A meeting of the Board of Directors of the Robina Foundation, a Minnesota nonprofit corporation, was held on May 20, 2008 via conference call.

The following Directors were in attendance at the meeting: Gordon Aamoth, Thomas Crosby, Edson Spencer, Peter Karoff, Steven Schroeder.

Jean Sazevich, foundation consultant, was also present and served as recorder.

There were no Directors absent.

**Call to Order**

Gordon Aamoth, President, called the meeting to order and welcomed board members.

**Conflict of Interest Policy and Disclosures**

There were no new disclosures by board members of situations that would pose a conflict of interest with their service on the board.

**Minutes**

The minutes of the January 28-29, 2008 board meeting were reviewed by the Board. There were no corrections. It was recommended that the minutes be paginated in the future. A motion was made and seconded to approve the minutes. A vote was taken and the motion passed unanimously.

**President's Report**

Gordon Aamoth reported some of the recent activities he has undertaken as Executive Director. These activities are summarized in written reports (February/March and April/May) included in the board book. He will continue to provide written updates to the board on a bi-monthly basis.

*Future Meetings:*

Gordon briefed the board on plans for future meetings. He noted that the August meeting in Minneapolis coincides with the Republican National Convention so board members should make travel plans soon. The August board meeting begins with dinner on August 25<sup>th</sup> and will conclude by Noon on August 27<sup>th</sup>. Gordon further suggested that the board hold its winter board meeting in California and that one day of the meeting be dedicated to education on the topic of human rights. The board agreed to the suggested format and set the dates of February 16-17 for the meeting. The location will be determined. It was noted that outgoing

board member Ed Spencer will be invited to attend the meeting based on his strong interest in and knowledge of human rights issues.

#### *Robina Land Dedication:*

It was reported that a formal dedication of the Lake Robina land that the Foundation donated to the Minnesota Department of Natural Resources (DNR) was held on Friday, May 16<sup>th</sup>. The event was well planned and there was good attendance. Most importantly, the Binger family was well represented, including Jim Binger's daughter and granddaughter. The Commissioner of the DNR made remarks as well Gordon, Jim Binger's granddaughter and Jim Binger's good friend Wheelock Whitney. The Commissioner was directly asked to reconsider whether or not the riding of horses could be allowed on the land. He said he was open to revisiting the issue.

#### *Human Rights Research Scan:*

Gordon asked the board to review a draft of a Request for Proposals (RFP) for a research scan on the topic of human rights that was included in the board book. Gordon noted that the draft RFP was developed with input from Peter Karoff. The purpose of a research scan would be to inform the board on key human rights issues and various approaches currently being used by other funders. This information would then be used by the board to develop funding strategies should the board decide to launch an initiative in the future. The research conducted would also help the board determine who it may want to invite to the winter 2009 board retreat on the topic.

The board agreed that issuing the RFP, as written, was appropriate and suggested that a budget of \$10-25,000 be set aside for the project. It was further suggested that the RFP be sent to Yale Law School, the University of Minnesota Center for Human Rights, the University of Minnesota Human Rights Program, The Philanthropic Initiative, and Human Rights Watch for their consideration. Jean asked the board members to forward her names of other suggested recipients as soon as possible. Steve Schroeder stated that he would very much like to have Dean of the Yale Law School, Harold Koh, be invited to speak at the winter board meeting.

#### *Ed Spencer Resignation and Nominations Process:*

Gordon acknowledged the pending resignation of Robina board member and Treasurer, Edson Spencer. Ed anticipates serving through the August 2008 board meeting when his replacement can be approved.

Gordon, on behalf of the entire board, thanked Ed for his leadership and significant contributions to the financial affairs of the Foundation, including development of an investment strategy.

Ed stated that he sincerely enjoyed his service on the board and feels it is the right time to step aside and make room for someone who can provide strong financial oversight for a longer term.

The board discussed criteria and strategies for the nomination of future board members. After significant discussion, the board determined that it would seek to add two new board members

in the next year, one to replace Ed Spencer and one new board member. It was further agreed that:

- One of the two new board members should be a Twin Cities area resident, preferably a woman, with strong financial experience.
- The other board member should be a non-Minnesota resident, a generalist rather than a specialist, and have a reputation as a "wise person."
- The sitting Minnesota board members will lead the process to locate and nominate the new Twin Cities based board member, bringing a consensus recommendation to the full board at its August meeting.
- The full board will begin floating names for consideration for the "national" board member at its August meeting with the goal of voting on a final candidate later in the year or in early 2009.

The board did not decide whether or not to interview prospective candidates prior to guaranteeing that they would subsequently be nominated for a board position and approved by the full board.

#### *Robina Insurance:*

Gordon informed the board that the policy for Directors and Officers Liability Insurance has been renewed and that the property insurance coverage was recently revised to eliminate coverage for the Robina land that was donated to the Minnesota Department of Natural Resources.

#### **Finance Committee**

Ed Spencer reviewed the quarterly statement provided by JP Morgan on the assets held in the Binger estate. He stated that, in his estimation, there are roughly \$95 million of additional assets in the estate that will eventually be transferred to the Foundation. Distribution of the assets continues to be held up due to the ongoing review by the IRS. Roughly \$65 million of the total assets are more "liquid" and should be able to be distributed to the Foundation more quickly once the IRS review process is concluded. There has been some recent loss in asset value due to the downturn in the economy.

There was some discussion of the fact that the estate may recover roughly \$15-20 million of additional assets from a disputed gift tax refund. However, realizing these funds may involve lengthy and costly court action.

Ed stated that, at the time the estate distributes assets to the Foundation, he would propose selling the equity assets and dividing the proceeds between the Foundation's current asset managers: The Investment Fund for Foundations (TIFF) and US Bank. The Foundation assets currently held by these managers totals roughly \$33 million. The income generated by these assets is currently adequate to cover all of Robina's grantmaking and overhead expenses, including asset manager fees.

#### **Legal Update**

Tom Crosby provided an update on the IRS review of the Binger estate. He stated that the IRS needs to formally state its position on the estate, including any liabilities owed to the estate or refunds due to the estate, by August 3, 2008. The parties continue to work out issues related to the valuation of assets. Tom stated that the positions on valuation taken by the IRS would not cause the estate to have to pay much money back to the IRS, so the likelihood of the Foundation receiving additional distributions sooner from the estate is positive. Tom also stated that he believes the estate, and subsequently the Foundation, will likely recover the additional \$15-20 million in assets from the gift tax recovery. Much more will be known regarding the final position on the estate and any subsequent appeal by the end of the calendar year.

The board agreed that once the amount and timeframe for asset distribution to the Foundation becomes clear, a "capacity scenario" should be developed to guide the board in determining its future grantmaking and payout strategies.

### **Finance – continued**

Financial statements for the quarter ending March 31, 2008 were reviewed and approved by the board. Gordon noted that there was a significant increase in expenses over the same quarter of the prior year due to the establishment of the Foundation office and hiring of the consulting team.

Jean Sazevich stated that she is in the process of developing a Request for Proposals for audit services. The RFP will be sent out to local auditing firms that specialize in audits for nonprofit organizations and foundations in July with the goal of selecting an auditor by fall 2008.

Gordon stated that the Foundation has renewed its membership in the Minnesota Council on Foundations for 2008. Membership dues for 2008 were nominal at \$500 due to the fact the Foundation did not make cash grants during 2007. Future dues will be based on the amount of cash grants in the prior year, so the benefits of membership compared to cost will be assessed more thoroughly.

### **Grants Committee**

Steve Schroeder, Chair of the Grants Committee, led the board in a "status update" on grants made and proposals in process.

Of the four institutions eligible to receive grants from Robina, two, Yale University (Drama School) and the Council on Foreign Relations, have received significant grants. The University of Minnesota Law School also received a small grant recently to assist with faculty retention. Abbott Northwestern Hospital (ANW) and the University of Minnesota Law School have significant proposals in process that will be considered by the board soon.

Regarding the anticipated ANW proposal, it was determined that the board will need to determine whether or not it is "on the mark" and ready to fund. It was suggested that staff convey a message to ANW that funding of the revised proposal is not guaranteed. Gordon noted that when he, Tom and Jean met with the ANW team members in late February, they explained that the revised proposal would need to be thoroughly reviewed. Concerns remain

about the scale of the project and whether or not the work proposed fits the core competency of the institution.

The work supported by the grant to the Council on Foreign Relations (CFR) is underway and staff has been hired. It was agreed that staff will ask CFR for a brief written progress report for inclusion in the August board book. Jean noted that CFR also plans to develop evaluation benchmarks for the project by summer for the Foundation to review.

Based on their report, it appears that the recent grant to the University of Minnesota Law School was very helpful and that the new Dean is off to a strong start. Gordon noted that the Law School's large proposal is being revised and should be received by the Foundation in early July. Dean Wippman will present the request at the August board meeting.

The work supported by the grant to Yale Drama School is underway. It was agreed that staff will ask Yale Drama for a brief written progress report for inclusion in the August board book. It was suggested that the board may want to ask for a more detailed "operating plan" from Yale Drama.

The board reviewed and discussed a request from Yale Law School for a new project, the Robina Foundation Human Rights Fellowship Initiative. The total amount requested is \$3 million/3 years. After significant discussion, the board unanimously agreed to approve the request in the full amount requested. The board was impressed with the specificity of the proposal and its significant focus on developing future leaders in the field of human rights. It was agreed that staff should ask Yale to provide some additional information about the sustainability of the initiative as well as plans for evaluation that would go beyond the level of gathering anecdotal information.

The board briefly reviewed and discussed a memo that proposed an initial plan for grantee monitoring and evaluation. There was general agreement that the memo was on track and aligned with the board's goals of monitoring without micro-managing grantee organizations. The board believes that the type and level of monitoring/evaluation should be different for each grant/grantee based on unique issues and circumstances involved. Each grantee will be asked to develop benchmarks that are meaningful and helpful to them. It was agreed that the board will spend additional time at its August board meeting reviewing the memo and discussing the topic of monitoring and evaluation.

### **Adjournment**

There being no other business, the meeting was adjourned.

Respectfully Submitted,

\_\_\_\_\_  
Steven A. Schroeder, Secretary

Dated: \_\_\_\_\_





EDSON W. SPENCER  
4900 IDS CENTER, 80 SOUTH EIGHTH STREET, MINNEAPOLIS, MN 55402  
TELEPHONE 612/333-3650  
FAX 612/333-3719

March 20, 2008

Gordon M. Aamoth, MD  
President  
Robina Foundation  
4900 IDS Center  
80 South 8<sup>th</sup> Street  
Minneapolis, MN 55402

Dear Gordy,

Last year when elected to serve another year on your Board, I said I might serve only one year, but would wait and see.

I have decided not to be reelected at the Robina Annual Meeting in August. The reasons are the following:

1. I will be 82 this year and am exiting all boards on which I serve.
2. The job of the Treasurer, until the main part of the Estate is distributed, is largely scorekeeping.
3. You need to get your longer range Treasurer on board soon, so he can familiarize himself with the Foundation and be prepared to handle the rest of the Estate when distributed.

Best regards,





**JOB DESCRIPTION**  
**DIRECTOR, ROBINA FOUNDATION**

**PURPOSE:** To act as a voting member of the Board of Directors of the Robina Foundation, with full authority and responsibility to develop policies, procedures and regulations for the operation of the organization; to monitor Robina's finances, programs, and overall performance; and to provide the President with the resources to meet the needs of Robina and the community it serves.

**Title:** Director

**Term:** Three (3) year term, renewable, expiring at the Board of Director's Annual Meeting

**Attendance:** Attend quarterly Board Meetings, retreats, and special events

**Responsibilities:**

- Establish policy
- Hire and fire Robina President and CEO
- Monitor finances
- Fill Board vacancies
- Review grants and approve, or disapprove
- Meet with grantees
- Monitor grantees for performance
- Assure finances are adequate for current and long-term commitments
- Review and revise Investment Policy Statement
- Approve spending and Spending Policy Statement
- Review and approve audit
- Assure management has appropriate policies to identify conflicts of interest and is diligently administering and enforcing Board policies, including laws affecting the Robina Foundation
- Read and be prepared to comment on information in the quarterly Board Meeting books
- Provide candid and constructive criticism, advice, and comments

**Board Members Can Expect:**

- Staff support
- Meeting dates long in advance
- Board Books in advance of meetings
- A positive "Board culture" that allows your contribution to further the mission, vision, and goals of the Robina Foundation

**ROBINA FOUNDATION BOARD SLATE**

**August 26-27, 2008**

| <b>Name/Office</b>                              | <b>Elected to 1st Term</b> | <b>1st Term Expires</b>                          | <b>Elected to 2<sup>nd</sup> Term</b> |
|-------------------------------------------------|----------------------------|--------------------------------------------------|---------------------------------------|
| <b>Gordon M.Aamoth, MD<br/>President</b>        | <b>9/1/04</b>              | <b>8/31/07</b>                                   | <b>9/1/07 – 8/31/10</b>               |
| <b>Steven Schroeder, MD<br/>Secretary</b>       | <b>9/1/04</b>              | <b>8/31/07</b>                                   | <b>9/1/07 – 8/31/10</b>               |
| <b>Edson W. Spencer<br/>Treasurer</b>           | <b>12/1/06</b>             | <b>8/31/09<br/>Resignation as of<br/>8/27/08</b> |                                       |
| <b>Peter Karoff</b>                             | <b>12/1/06</b>             | <b>8/31/09</b>                                   |                                       |
| <b>Thomas M. Crosby, Jr.<br/>Vice President</b> | <b>2/20/07</b>             | <b>8/31/10</b>                                   |                                       |



# ROBINA FOUNDATION

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80 South 8<sup>th</sup> Street  
Minneapolis, MN 55402  
Phone: 612-333-2313  
Fax: 612-333-0182  
[www.robinafoundation.org](http://www.robinafoundation.org)

DATE: August 14, 2008  
TO: Robina Board Members  
FROM: Gordon Aamoth  
SUBJECT: PRESIDENT'S REPORT TO BOARD OF DIRECTORS – June – August 2008

## Office Management/Administration

The office functions well and efficiently with Nancy Gilberg, Administrative Consultant; Jean Sazevich, Managing Consultant; and Gordon Aamoth, President and Executive Director.

At the last Board of Director's Meeting, May 2008, the Board decided to add two new Directors, one local and one national. Tom Crosby, Ed Spencer, and I each nominated a local candidate. All three were excellent qualified people and Lois Quan has agreed to a three-year renewable term (see Board Book for bio).

The winter Board of Director's Meeting retreat will be a one-day discussion on Human Rights. The Committee of Peter Karoff, Gordon Aamoth, and Jean Sazevich sent an RFP for a research scan to Yale Law School, University of Minnesota Human Rights Department, and TPI, selecting UM lead by Barbara Frey (see Board Book). The research scan will include a relevant literature search, key informant interviews of leading thinkers in this field, and identification of major human rights, issues, common themes, opportunities and strategies for consideration by our Board at the retreat in February 2009.

Steve Schroeder was the guest speaker at the Allina Medical System Annual Meeting in Minneapolis on June 8, 2008. It was a provocative talk about health issues in the U.S. compared to other developed countries and the major medical issues of our time, smoking and obesity.

On June 16, 2008 we paid our Federal Excise Tax estimate of \$11,000 which is based on our net income through March, annualized.

## Grantmaking/External Relations

On June 10, 2008, Steve Schroeder, while in Minneapolis, met with the Abbott Northwestern committee developing its proposal for a Robina Grant. On June 17, Tom Crosby, Jean Sazevich, and I met with the same group to hear what they planned to present to our BOD – we think they "have it right" this time. On July 21<sup>st</sup>, they delivered their proposal which has been forwarded to you for your reviewal.

The Council on Foreign Relations (CFR) provided a status report July 7<sup>th</sup> on its program's organization and benchmarks for success (see Board Book). They are just getting started since Dr. Steward Patrick, PI for the project, joined CFR on April 30, 2008.

The University of Minnesota Law School submitted its revised proposal and budget June 20<sup>th</sup>, "New Directions in Legal Education and Research: The Program on Law, Public Policy, and Society." Dean David Wippman started on July 1, 2008, and will direct this initiative.

The Yale Law School was granted \$1,000,000 as part of a three-year/\$3,000,000 grant to support the Robina Yale Law School fellowship in Human Rights under the direction of Dean Harold Koh. The Fellowship will support students, scholars, and practicing lawyers studying International human rights.

#### Assets/Investments

The Foundation has, after receiving money from the James Binger Estate and after calculating the estimated remainder of the Estate after payment due the IRS, established its spending statement on which we have drafted an Investment Policy Statement (IPS). This will set the course for managing the Foundation's assets over time. The IPS fundamentally sets the fiduciary duties of the Foundation Directors which the law requires be done.

The 2<sup>nd</sup> Quarter financial statement from CBIZ, our accountants, is in the Board Book. Our assets are reported in the USBank and TIFF Statements of June 30, 2008, and as might be expected, considering the economic times, are lower than hoped for.

Tom Crosby, Ed Spencer, and I have been in regular contact with J. P. Morgan and McDermott Will law firm as well as attorney's for the Binger family, regarding the Estate Audit. It appears the IRS is willing to negotiate the value of the various assets of the Estate but not the refund as a result of the mediated settlement with Jane Mauer. Tom Crosby will give an update regarding the legal issues at stake.

#### Future BOD Meetings

Our next meeting will be a Conference Call on November 19, 2008, 9-11 CST. We will meet February 16 and 17, 2009 in La Jolla, California for a business meeting and retreat on international human rights as mentioned earlier. The purpose of the retreat is to educate the Directors, to consider what current philanthropy is going on, and to decide if this is what we want to do in future grantmaking. The 2009 schedule will be set at our August meeting, so please bring your calendars.

**Robina Foundation  
Human Rights Research Scan  
Summary of Proposals  
June 23, 2008**

**Background**

At its meeting on May 20, 2008, the Board of Directors of the Robina Foundation approved a Request for Proposals (RFP) for a research scan on various human rights issues. A copy of the RFP is attached. Subsequent to its approval, the RFP was sent to the following organizations/individuals for their consideration:

Yale Law School, Dean Harold Koh  
University of MN, Law School, Human Rights Centers, David Weissbrodt, Director  
University of MN, College of Liberal Arts, Human Rights Program, Barbara Frey, Director  
The Philanthropic Initiative (via email from Peter Karoff)  
Human Rights Watch, Kenneth Roth, Executive Director  
Giovanna del' Orto, PhD, independent researcher and author

The deadline for responses to the RFP was June 20, 2008. As of June 23, two of the recipients of the RFP had responded: Yale Law School and University of Minnesota. A brief summary of their proposals is found below. Complete proposals and attachments have been emailed separately.

**Applicant Organization:** Yale Law School

**Key Personnel:**

Harold Koh, Dean (15 hours)  
Hope Metcalf, Clinical Instructor, Associate Research Scholar and Lecturer in Law (40 hours)

**Preliminary Budget:** \$11,250

**Observations/Questions:**

- Unclear how much of the proposed research will be original to this project vs. prior Koh work
- Principal researcher appears highly qualified
- Approach is fairly broad with some specific topics proposed for in depth coverage
- Proposal does not assume end goal is collaborative project among Robina grantees
- Proposed deliverables include a "funding strategy" for the next 3-5 years, need to clarify

**Applicant Organization:** University of Minnesota, Human Rights Program

**Key Personnel:**

Barbara Frey, Director (10-12 days)

Catherine Sikkink, Professor of Political Science (3 days)

David Weissbrodt, Director of Human Rights Program (in-kind advice)

**Preliminary Budget:** \$20,000-\$22,400

**Observations/Questions:**

- Proposal is a collaborative effort between two different centers for human rights at the University of MN --- one within the Law School and one within the College of Liberal Arts. No funds from this project are proposed to flow to the staff of the Human Rights Center at the Law School.
- Proposed approach includes conversations with the four Robina grantee institutions to help determine possible focus for future collaborative/parallel effort. The board needs to clarify whether this step is appropriate at this phase of the research and exploration process.
- Barbara Frey is an extremely well qualified principal investigator with strong connections in the field
- Thoughtful timeline for proposed work is included

**Robina Foundation  
Human Rights Research Scan  
Summary of Proposals  
July 13, 2008**

**Applicant Organization:** The Philanthropic Initiative (TPI)

**Key Personnel:**

Members of TPI's research staff will form the research team. The bios of staff included with the proposal show at least one staffer, Sharon Cohen, has significant experience in the area of human rights funding. Other team members have experience in the various fields identified in the RFP.

**Preliminary Budget:** \$28-36K estimated based on 14-18 days

**Observations/Questions:**

- Proposed work plan appears to align well with RFP objectives at this initial stage, especially with regard to understanding the initiatives underway or planned by private foundations
- Work plan provides less detail than other two regarding resources to be contacted, interviewees, etc. Additional detail could be requested
- Budget for this proposal is significantly higher than the other two proposals for only slightly more days of proposed work



To: The Robina Foundation Board, Gordon Aamoth, Chair

From: Barbara Frey and Kathryn Sikkink

Re: Final research plan

Date: August 13, 2008

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We are pleased to be working with the Robina Foundation on its exploration of human rights as an area of interest for its philanthropic focus. The following is our final plan for conducting a research scan for the Foundation regarding the field of human rights, including a review of common human rights initiatives in the fields of law, medicine and foreign policy. We intend to provide the Robina Foundation with background on key human rights principles and issues, as well as an analysis of promising developments in human rights protection, so that the Board is prepared to engage in an informed consideration of philanthropic opportunities and strategies in the field.

Barbara Frey will be the lead consultant on this project; Professor Kathryn Sikkink will assist with interviews, research and drafting as an additional paid consultant. Frey and Sikkink will consult Professor David Weissbrodt as a sounding board on this research scan, but he will not be paid for his advice on the project because of his employment in one of the Foundation's beneficiary institutions. Biographical information about the consultant team can be found in Annex 1.

### **Methodology**

Each member of our consulting team is engaged in human rights research, advocacy and programmatic work which will inform our work on this project. In addition, we will carry out our research for the Foundation through the following means:

- a review of relevant literature in human rights, specifically in law, medicine and foreign policy;
- interviews with key informants, including leading human rights experts in the philanthropic community, academia, intergovernmental organizations such as the United Nations, and nongovernmental organizations working in the field of human rights.

### **Outcomes**

We will inform the Foundation of our findings by means of several work products:

- An annotated bibliography of key human rights sources, including general background, information on select human rights themes, and a summary of current funding in the field by major foundations;

- A summary of interviews with leading human rights experts;
- A preliminary report providing a general overview of the field of human rights, key laws, institutions and experts, as well as presenting common themes in law, medicine and foreign policy, and the opportunities and challenges regarding proposed human rights initiatives in those common thematic areas;
- A final report analyzing proposed investments in strategic human rights initiatives and analysis of their potential impacts;
- A presentation at the Robina Foundation retreat in February 2009.

### **Why Human Rights?**

With the advent of the United Nations Charter in 1945, human rights were recognized as fundamental principles of international law and a State's human rights performance has become a subject for consideration in foreign policy, trade, investment, tourism, and every other aspect of international relations. In making human rights one of the founding purposes and principles of the United Nations, the international community made clear that a State's treatment of its own residents is now a subject of international concern. In the words of the American Jewish Committee in 1945:

*No plea of sovereignty shall ever again be allowed to permit any nation to deprive those within its borders of fundamental rights on the claim that they are matters of internal concern.*

This international shift to endow individuals with fundamental human rights that must be protected by their governments had roots in American and European conceptions of individual rights, but a wide range of countries with various cultures and legal systems have joined in promulgating and ratifying the core human rights treaties and other legal instruments. There is no doubt that every government and culture – even those most critical of the West – have embraced the notion that all humans have basic human rights regardless of their nationality, religion, race, gender, or any other innate characteristic.

Indeed, over the 60 years since the adoption of the Universal Declaration of Human Rights, which its drafter Eleanor Roosevelt deemed the “international Magna Carta,” the rights contained in that Declaration have been elaborated and implemented at a remarkable pace. There are now ten major human rights treaties, on:

- civil and political rights
- economic, social and cultural rights
- genocide
- race discrimination
- discrimination against women
- torture
- rights of the child
- rights of migrant workers and their families
- rights of persons with disabilities, and
- protection from enforced disappearance.

The adoption of legal norms and creation of related international mechanisms for the implementation of those norms are significant achievements, but we know that it is only the first step in providing real protections to human beings. In recognition of the change that human rights law has made upon the landscape of international law, States have reacted to these new obligations in various ways – sometimes accepting the obligations and sometimes seeking exceptions to them. The past decade, in particular, has been characterized by contradictory trends in international human rights protection. One trend is toward expanded human rights protection. There have been notable gains in the recognition of new and broader rights, especially for those persons who may not have been emphasized in the first wave of human rights laws including children, women, migrants, indigenous peoples and social outcasts such as the “Dalits” or untouchables in Hindu nations. The past decade has witnessed significant advances in international justice, including prosecutions for genocide, war crimes and crimes against humanity. There has been as well an increased emphasis on economic, social and cultural rights, including the rights to health, housing, and education.

The contradictory trend has been the diminishment of certain core civil and political rights due, in large part, to the decisions of the major international powers, especially the United States Government, in response to the threat of global terrorism. Like every sphere of international relations, human rights institutions and actors were profoundly affected by the events of 9/11. These unjustifiable attacks were universally condemned by the human rights community, which immediately identified them as crimes against humanity. The U.S. Government’s response, however, dramatically shifted our historical posture as a nation, away from being a proponent of human rights laws and protections, toward retrenchment from human rights obligations that were seen by the Bush Administration as constraints upon its ability to carry out the “war on terror.”

This shift in the U.S. approach to human rights has had tremendous repercussions throughout the world community. The U.S. Government has taken steps to exempt itself from several international legal commitments, especially in the areas of human rights and international humanitarian law. The U.S.’s policies have led to questioning the most basic human rights principles, including freedom from arbitrary arrest and torture, as well as the right to a fair trial. Unfortunately, as we know from experience in the human rights community, when the U.S. loosens human rights norms, then governments around the world feel empowered to do the same, knowing that they will not face retribution by the international community for doing so.

In this historic moment, then, we are at the intersection of a progressive international movement that seeks further protection for human rights, and a retrenchment from those rights led by the world’s most important power, the United States. As we face a change in U.S. leadership in November’s presidential election, with growing economic and environmental pressures on the global community, this moment is an opportune time for the Robina Foundation to help shape the discussion about respect for human rights in the world today. The Foundation’s initiatives in research, policy, and practice could help motivate a new generation of ideas and action regarding human rights and human dignity.

## **Human rights issues in law, medicine, and foreign policy**

Our approach to achieving effective long-term improvements in human rights practice rests on the belief that investments in leadership, scholarship, and institutional support for the study of human rights are the keys to success. Elite institutions, like the four recipient organizations identified by Mr. Binger for enduring support, already shape our national and international policy discussions. Getting those institutions to focus their expertise in a more significant way on the pressing human rights questions of our time would have an important and lasting impact on the way those questions are answered.

Given the Foundation's interest in the three key areas of law, medicine, and foreign policy we will undertake a research scan that will identify potential themes that can encourage the four identified recipients to use their comparative strengths to promote human rights. We have identified some broad human rights themes for the Foundation's consideration and feedback in shaping this consultancy and, in our discussions with the Board Chair, those themes have met with preliminary approval. These ideas offer content that might be helpful in discerning the general direction for the Foundation's investments in human rights. The themes are suggested in part because of what we perceive to be the comparative advantages and expertise of the beneficiary organizations.

1. The impacts of torture: What are the impacts of the use of torture on our communities and our world? Under this theme, the Foundation could encourage research on the personal, family, community, and foreign policy impacts of torture. Such research could, for instance, engage medical expertise to carry out an assessment of the ecology of torture survivors, including their health care needs, the effects on their relationships and families, their productivity in the workplace, and other factors. Other research directions might investigate the foreign policy implications of the U.S. Government's torture policies and practices. We think it is an opportune moment to consider what the four recipient organizations can contribute to an overall effort to prevent torture, to provide medical and legal assistance to torture victims, and to hold perpetrators responsible for torture.

2. The rights of non-citizens: In our increasingly mobile world, what should be our human rights policies and principles regarding non-citizens, including visitors, immigrants, refugees, undocumented workers, and temporary workers? This theme, drawn broadly or narrowly, would encourage scholarship, research, and policy discussions about how the U.S. and other States should treat non-citizens. Diverse research undertakings might address, for example, comparative notions of citizenship; legal and ethical obligations toward non-nationals in the areas of health, education, or worker safety; and a critical analysis of the objectives and operations of international refugee policy. What can the four recipient organizations contribute to an overall effort to prevent discrimination against non-citizens, to provide medical and legal assistance to non-citizens, and to propose constructive foreign policy proposals regarding issues of international migration?

3. The right to health: In a global environment characterized by unequal access to resources, how can we best fulfill the individual's right to the enjoyment of the highest attainable standard of physical and mental health? This broad theme could encourage investigations into human rights in the face of potential pandemics, HIV/AIDS, access to health care, clean water, and food. The theme might also stimulate research and other efforts on medical, legal and foreign policy consequences of trade or transfer of harmful substances such as tobacco, firearms, or toxic waste.

4. Accountability for human rights violations: How can and should those responsible for serious human rights violations be held accountable for their actions? The demand for accountability has led to a growing new field of "transitional justice," a term that embraces the legal, political, and social processes created in societies emerging from repressive periods characterized by human rights violations and armed conflict. Trials, truth commissions, memorials, and other practices have been designed to offer redress to survivors of terrible violations. The Foundation may be interested in encouraging careful research and other activities on the effectiveness of such mechanisms in achieving their objectives including truth-telling, reconciliation, peace and justice and on forward-looking recommendations regarding accountability.

5. Other themes: Besides these four broad themes, we would be pleased to review other ideas for the Foundation to consider as potential groundbreaking initiatives on themes including hunger and human rights, children's rights, women's human rights including prevention of violence against women, the rights of persons with disabilities, and theatrical, literary, and artistic approaches to human rights.

### **Timeline for Project**

- August 1: Submitted proposed list of key informants and preliminary interview questions for the scan; submitted preliminary annotated bibliography. (Frey)
- August 14: Submitted final outline of research plan and budget for August Board meeting. (Frey)
- August- Sept: Interviews with human rights experts in philanthropy, academia, international organizations including the United Nations, and nongovernmental organizations to gather information about key issues and gaps in law, medicine and foreign policy regarding the identified key themes. Interviews will be conducted in Minneapolis, Chicago and New York in person, the remainder by phone. (Frey, Sikkink)
- October 10: Deliver preliminary report to Robina Foundation including:
- a general overview of human rights laws, institutions, and experts;
  - presentation of important common themes and issues that overlap the fields of law, medicine and foreign policy;
  - a summary of interviews with human rights experts;



- final annotated bibliography of key human rights sources, including general background, information on select human rights themes, and a summary of current funding in the field by major foundations;
- a preliminary analysis of opportunities and challenges regarding potential human rights initiatives in overlapping thematic areas

(Frey with input from Sikkink, Weissbrodt)

- October: Hold discussions with Robina Foundation regarding direction for final report. (Frey)
- Nov 14: Delivery of final report including analysis and recommendations regarding potential philanthropic investments in strategic human rights initiatives and their potential impacts. (Frey with input from Sikkink, Weissbrodt)
- Feb 2009: Board Retreat presentation by Frey and Sikkink

#### **Project Budget: July 2008 – February 2009**

The following is a budget to support the human rights research scan for the Robina Foundation. This budget does not include time or expenses related to Barbara Frey's or Kathryn Sikkink's participation in the February 2009 Board retreat in La Joya, CA.

##### **Personnel**

|                               |          |
|-------------------------------|----------|
| Frey (12 days x \$1200) =     | \$14,400 |
| Sikkink (3 days x \$1500) =   | \$ 4,500 |
| Weissbrodt (in-kind advice) = | \$ 0     |

##### **Travel**

To NYC (Frey and Sikkink for interviews with Human Rights experts):

|                                    |         |
|------------------------------------|---------|
| Airfare (\$600 x 1) <sup>1</sup> = | \$ 600  |
| Housing (\$500 x 3 nights) =       | \$1,500 |
| Local transportation/food =        | \$ 500  |

##### **Office Expenses**

|                                 |        |
|---------------------------------|--------|
| Telephone, supplies, printing = | \$ 500 |
|---------------------------------|--------|

**Total: \$22,000**

<sup>1</sup> Sikkink will be in New York for another meeting, which will cover her airfare. Her extra night of accommodations and expenses will be covered by this contract.

## **Conclusion**

We are pleased and honored to work with the Robina Foundation on this important investigation of human rights as a subject for philanthropic investment. Please let us know if this research plan adequately addresses the expectations of the Board. We look forward to engaging with the Foundation in a meaningful discussion about innovative and future-looking initiatives in human rights. Thank you again for engaging us in the effort.

*Thank you for your help and support.*  
*Very truly yours,*

**Annex 1: Biographical information of consultants to the Robina Foundation**  
**August 2008**

**Barbara A. Frey** is Director of the Human Rights Program in the College of Liberal Arts at the University of Minnesota. The Program, established in 2001, provides academic, research and internship opportunities for students in the field of international human rights.

Frey is well known as an international human rights teacher, advocate and scholar. She served from 2000-2003 as an alternate U.S. member of the U.N. Sub-Commission on the Promotion and Protection of Human Rights (along with David Weissbrodt, who was the principal U.S. member), a body of independent experts who advise the United Nations on human rights policy. From 2002-2006 Frey served as Special Rapporteur of the Sub-Commission to conduct a study on the issue of preventing human rights abuses committed with small arms and light weapons. From 1985 through 1996 Frey was Executive Director of Minnesota Advocates for Human Rights. She is a co-convener of the Midwest Coalition for Human Rights, a network of 44 organizations working to promote research and advocacy on human rights issues.

Frey is the recipient of the 2008 Don and Arvonne Fraser Award from The Advocates for Human Rights. She was recently recognized with the 2008 Outstanding Community Service Faculty Award from the University of Minnesota. Other awards Frey has received included the first *Iustitia et Lex* award from the University of St. Thomas Law School in 2003, and the 2001 Myra Bradwell Award from Minnesota Women Lawyers for promoting the interests of women in the legal profession and in the community. She is the immediate past Chair of the St. Paul-Minneapolis Committee on Foreign Relations. Frey attended the University of Notre Dame (BA, 1978) and the University of Wisconsin Law School (JD, 1982). She worked as an associate lawyer at Dorsey & Whitney in Minneapolis from 1983-85.

**Kathryn Sikkink** is a Regents Professor and the Arleen Carlson Chair in the Department of Political Science at the University of Minnesota. Professor Sikkink's intellectual work on constructing human rights norms has forged an important new sub-field in political science and her work has had important impacts not only in academic circles but in nongovernmental activism and governmental policy.

Professor Sikkink works on the role of ideas and norms in the international system and in domestic politics, with emphasis on the origins and effects of international human rights ideas and regimes. She is especially interested in how transnational social movements and networks have developed new norms and pressured states and international organizations to change practices. Her current research focuses on the dramatic increase in international, foreign, and domestic human rights trials in the world. She received a Guggenheim Fellowship for 2008-09 to complete her research on human rights trials.

Professor Sikkink received her B.A. from the University of Minnesota, and has a M.A. and a Ph.D. in political science from Columbia University. She has received many awards in recognition of her distinguished academic work, including a McKnight Land Grant



Professorship, a Fulbright Scholar Award to Argentina in 2001 – 2002, the Graduate-Professional Teaching Award, University of Minnesota, 2004, and the McKnight Distinguished University Professorship in 2004. She is a member the American Academy of Arts and Sciences and the Council on Foreign Relations. She served on the Editorial Boards of *International Studies Quarterly* and the *American Political Science Review*. Her publications include *Ideas and Institutions: Developmentalism in Brazil and Argentina*; *Activists Beyond Borders: Advocacy Networks in International Politics*, (co-authored with Margaret Keck), winner of the Grawemeyer Award for Ideas Improving World Order (1999) and the International Studies Association's Chadwick Alger Award for best work in the area of international organization (1999); and *Mixed Messages: U.S. Human Rights Policy and Latin America* (2004).

**David Weissbrodt** is a faculty member and the Co-Director of the Human Rights Center at the University of Minnesota Law School. Weissbrodt is a world-renowned scholar and advocate in international human rights law. David Weissbrodt was selected in 2005 as the first and only Regents Professor of Law at the University of Minnesota. Professor Weissbrodt is the author of more than 200 articles, books, and monographs – mostly in the field of human rights. In 1996 Weissbrodt was elected and in 2000 he was re-elected by the U.N. Commission on Human Rights to serve as a member of the U.N. Sub-Commission on the Promotion and Protection of Human Rights. In 2001-02, Professor Weissbrodt became the first United States citizen since Eleanor Roosevelt to head a United Nations human rights body when he served as chairperson for the U.N. Sub-Commission on the Promotion and Protection of Human Rights.

Professor Weissbrodt helped to establish and continues to work with several human rights organizations including the Center for Victims of Torture, the International Human Rights Internship Program, and Advocates for Human Rights. He has also served on the Board and/or represented Amnesty International, the International Commission of Jurists, and the International League for Human Rights. For example, he recently completed a two-year term as a member of the International Executive Committee of Amnesty International.

To: , Board of Directors, Robina Foundation

From: Barbara Frey

Date: August 1, 2008

Re: Preliminary Bibliography

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Attached is a very basic bibliography of sources that might be helpful in getting grounded in the language and processes of human rights. I have tried to include some books that provide introductions and overviews to the field, as well as materials on a few key subjects. I've also tried to include some of the authors who are most prominent in the field so that you start to get familiar with their work. I intend to provide a more complete bibliography on August 14, as scheduled, which will include sources other than books, and focus on additional issues such as business, education, health, immigrants and refugees, and transitional justice. Please let me know if there are specific topics you want to make sure I include. All of these are available to order on line, and most of them are in my office if you want to borrow them!

Best,  
Barb

**A bibliography entry point into human rights issues, philosophy and law**

**Prepared for the Robina Foundation by Barbara Frey, August 1, 2008**

Buerghenthal, Thomas, Shelton, Dinah and Stewart, David. International Human Rights in a Nutshell, 3<sup>rd</sup> Ed. St. Paul, MN: West Group, 2002. A basic introduction to the law and practice of human rights, in the format of the Nutshell Series, intended as a concise overview and companion to law textbooks.

Clapham, Andrew. Human Rights: A Very Short Introduction. Oxford: Oxford University Press, 2007. Intended as an introduction for lay readers on the content of human rights; focuses on current issues including torture, arbitrary detention, privacy, health and discrimination.

Clapham, Andrew. Human Rights Obligations of Non-State Actors. Oxford: Oxford University Press, 2006. Thorough examination of the international legal framework as it applies to the protection of human rights threatened by private actors, including rebel groups, private security firms, corporations and international agencies.

Claude, Richard Pierre and Weston, Burns. Human Rights in the World Community: Issues and Action, 3<sup>rd</sup> Ed. Philadelphia: University of Pennsylvania Press, 2006. Anthology of human rights materials, principally for undergraduate classroom use. Thematic chapters are contributed by the major human rights academics and actors. Well-organized overview of issues, laws and institutions.

Donnelly, Jack. International Human Rights, 3<sup>rd</sup> Ed. Cambridge, MA: Westview Press, 2007. Leading political science text in the field of human rights.

Forsythe, David P. Human Rights in International Relations. Cambridge, UK: Cambridge University Press, 2000. Extended essay examining the evolution and status of human rights in the 21<sup>st</sup> Century. Views human rights as liberalism in contrast to traditional view of international relations which focuses on relationships between states.

Hunt, Lynn. Inventing Human Rights: A History. New York: W.W. Norton & Co., Inc., 2007. Professor of European history's investigation of the intellectual origins of human rights finds the answer in popular access to literature which promoted compassion for the other.

Kennedy, Kerry and Eddie Adams (photographs). Speak Truth to Power: Human Rights Defenders who are Changing our World. New York: Umbrage Editions, 2000. Photographic portraits and accompanying stories of 50 human rights heroes who have changed the world.

Koh, Harold Hongju and Slye Ronald, Deliberative Democracy and Human Rights, New Haven, CN, Yale University Press, 1999. Collected writings of leading legal and political thinkers address a wide array of issues that confront societies undergoing a transition to democratic rule.

Lockwood, Bert B. Women's Rights, A Human Rights Quarterly Reader. Baltimore, Johns Hopkins University Press, 2006. This is a collection of reprints of articles from this important journal covering history of women's human rights, and key issues including religion and culture, violence, economic rights and reproductive rights.

O'Byrne, Darren J. Human Rights: An Introduction. London: Pearson Education Series, 2003. A human rights reader which attempts to treat human rights as an academic discipline in its own right. Organized by major human rights issues including censorship, political prisoners, torture the death penalty, genocide.

Power, Samantha. A Problem from Hell: America and the Age of Genocide. (New York: Basic Books: 2002). Pulitzer prize-winning book documenting the crime of genocide and the U.S. foreign policy response (or lack thereof) to key genocides in the past century, from Armenia to Rwanda.

Roth, Kenneth and Worden, Minky (eds.), Torture: Does It Make Us Safer? Is It Ever OK?. New York: The New Press, 2005. Collection of short essays by twelve leading thinkers and experts covering the history, ethics, law and politics surrounding this timely issue.

Sikkink, Kathryn and Margaret E. Keck. Activists Beyond Borders: Advocacy Networks in International Politics, Ithaca: Cornell University Press (1998). Path-breaking analysis of the role of principled ideas and the entrepreneurs who advocate for those ideas in the domestic and international political arena.

Stromseth, Jane, Wippman, David and Brooks, Rosa. Can Might Make Rights? Building the Rule of Law after Military Intervention. Cambridge University Press, 2006. An analysis of the causes and legal and political consequences of military interventions and de facto governance in the 21<sup>st</sup> century.

Weissbrodt, David and de la Vega, Connie. International Human Rights Law: An Introduction. Philadelphia: University of Pennsylvania Press, 2007. A "point of departure" in understanding the basic international, regional and national laws and procedures to protect human rights.

Weston, Burns, Ed. Child Labor and Human Rights: Making Children Matter. Lynne Rienner Publishers, 2005. Collection of articles documenting child labor and proposing strategies to address the global dilemma.

To: Gordon Aamoth and Jean Sazevich, Robina Foundation

From: Barbara Frey

Date: August 1, 2008

Re: Potential Key Informants and Questions

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**Funders:**

Ford Foundation: Monette Zard  
Open Society Institute, Mirna Adjami, Sandra Coliver  
Atlantic Philanthropies: Gara LaMarche  
UN Foundation: Tim Wirth  
JEHT: Bob Crane, Garth Meintjes  
MacArthur Foundation: Jonathon Fanton, Mary Page  
Mertz Gilmore Foundation: Jay Beckner  
Nathan Cummings Foundation: Lance Lindblom  
Medtronic Foundation: Mark Lindberg  
Bremer Foundation: Karen Starr

**Human Rights Organizations**

Human Rights Watch: Ken Roth, Peggy Hicks  
Amnesty International: Larry Cox, David Petrasek  
Global Rights: Mary E. McClymont  
Advocates for Human Rights: Robin Phillips, Cheryl Thomas  
ECPAT (exploitation of children): Carol Smolenski  
Physicians for Human Rights: Len Rubenstein, Susannah Sirkin  
Human Rights First: Michael Posner, Elisa Massimino  
International Center for Transitional Justice: Juan Mendez  
Center for Victims of Torture: Doug Johnson  
International Council on Human Rights Policy: Magdalena Sepúlveda, Research Director  
Equality Now: Jessica Neuwirth

**Academy**

Joseph Nye: Kennedy School, Harvard  
Anne Marie Slaughter: Dean, Woodrow Wilson School, Princeton  
Peter Ackerman: Council on Foreign Relations  
Robert Keohane: Political Science Department, Princeton

**United Nations**

Office of High Commissioner: Craig Mokhiber  
Office of High Commissioner: Elsa Stamatapoulou  
Professor Philip Alston: Special Rapporteur on Extrajudicial Killing, NYU  
Radikha Coomaraswamy: Special Representative on Children in Armed Conflict

**Proposed Questions:**

What is the strategic focus of your (your organization's) work in human rights at this time? How are you (or the organizations you are supporting) carrying out that work? Comment on specific initiatives in the areas of law, medicine and foreign policy.

What kind of measurable outcomes are you seeing in the protection of human rights based on your organization's work (or the work of the organizations you support)? What have been the most effective strategies you or others have used to protect human rights on the ground?

What do you expect your focus on human rights to be a decade from now?

If you had twice the amount of money as you do now, how would you invest the extra money in your human rights agenda? Would you put twice as much effort on your current projects or would you work on additional issues?

What do you see as the gaps in human rights protection (or research) that are not being adequately addressed by the international community? Are there issues that are being over-emphasized at the cost of other important needs?



## ROBINA FUTURE FINANCES

### Assumptions:

1. Estate distributions and outgoing cash grants per attached numbers in 2009 and 2010.
2. \$4 million grants made to date in 2008. An additional \$4 million will be made before yearend to bring total grants in 2008 to \$8 million, per plan.
3. The bulk of the cash, venture funds, and miscellaneous investments will be distributed by J. P. Morgan to Robina in 2009. Only Tartan Investment Funds will remain to be distributed in 2010.
4. Distributions will be divided per attached recommendation between USBank Money Market and Fixed Income Funds for short and intermediate grantmaking, and the TIFF Multi-Asset Fund for the longer term.
5. The Tartan Investment cannot be distributed to Robina until a settlement is reached with the IRS on the discount taken when the funds were initially transferred to Tartan. Robina's 31.7% ownership of Tartan Investments should suffer no tax penalty, being a gift to a nonprofit. Hopefully these funds can be distributed in 2010 and will be deposited in the TIFF account.
6. The required 5% distribution of grants is approximately \$1.5 million in 2008 and approximately \$4.5 million in 2009. This will be more than covered by the \$8 million planned grants in 2009 and 2010. In addition we have a carry-forward credit of \$4.2 million from the gift of Lake Robina property to the Minnesota Department of Natural Resources.
7. We will continue to reinvest capital gains and income from the TIFF account back into the account. In the future, when more grant funds are needed, we can take a distribution of 5% of the asset value in the TIFF account without penalty. When we dip into assets beyond the 5% number, we pay a 0.5% penalty. Tiff and USBank accounts are net of fees.
8. The venture capital and private equity funds are valued at \$9 million. This is about the same as a very conservative estimate of future distributions. Distributions will go directly to the USBank account. There is still a \$1 million commitment to complete payments to these funds.
9. The Estate has \$595,000 in Binger's personal investments in stock and notes, plus a \$420,000 valued condominium. We are working on a valuation of the personal investments to see what (probably most) should be written off to zero at the time of distribution. We will probably have to get court approval to pay the taxes and association dues on the condominium as long as Marion Bazal (a former helper to the Binger family) lives in it, at which point we could sell it.



**PROJECTION OF CASH BALANCES (2009-2010 – based on June 30, 2008 numbers)**

**End 2008/Start 2009**

|                           |                   |              |
|---------------------------|-------------------|--------------|
| Checking Account          | \$ 50,000         |              |
| Money Market Fund         | 8,500,000         |              |
| Fixed Income Investments  | <u>11,700,000</u> |              |
| TOTAL USBank              | \$20,250,000      |              |
| TIFF Long Term Account    | \$8,500,000       |              |
| TOTAL END 2008/START 2009 |                   | \$28,750,000 |

**2009 Distributions from Estate**

|                                                                                                                                                                                                    |                |              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------|
| Cash from Estate                                                                                                                                                                                   | \$53,000,000*  |              |
| Venture Funds                                                                                                                                                                                      | 9,700,000      |              |
| Miscellaneous Assets (after write-offs)                                                                                                                                                            | <u>550,000</u> |              |
| TOTAL ESTATE DISTRIBUTIONS                                                                                                                                                                         |                | \$63,250,000 |
| *Reduced by \$2.5 million J. P. Morgan Executor Fees,<br>\$1.0 million committed to venture funds, and \$387,000<br>tax liability due to IRS settlement on the value of the<br>New York apartment. |                |              |
| Return on Investments at 3%*                                                                                                                                                                       |                | 3,000,000    |
| TOTAL CASH AVAILABLE in 2009                                                                                                                                                                       |                | \$95,000,000 |

**2009 Deductions**

|                                 |                  |                      |
|---------------------------------|------------------|----------------------|
| Budgeted Expenses               | \$ 500,000       |                      |
| Grants                          | <u>8,000,000</u> |                      |
| TOTAL DEDUCTIONS                |                  | <u>-\$ 8,500,000</u> |
| FUND IN FOUNDATION YEAREND 2009 |                  | \$86,500,000         |

**2010 Distributions**

|                              |                  |                   |
|------------------------------|------------------|-------------------|
| Tartan Funds                 | \$25,000,000     |                   |
| Mauer Note due 12/31/10      | 1,000,000        |                   |
| Return on Investments at 3%* | <u>2,500,000</u> |                   |
| TOTAL ADDITIONAL FUNDS       |                  | \$28,500,000      |
| Carry Forward from 2009      |                  | <u>86,500,000</u> |
| FUNDS AVAILABLE IN 2010      |                  | \$115,000,000     |

**2010 Deductions**

|                                  |                  |                    |
|----------------------------------|------------------|--------------------|
| Budgeted Expenses                | \$ 500,000       |                    |
| Grants                           | <u>8,000,000</u> |                    |
| TOTAL DEDUCTIONS                 |                  | <u>\$8,500,000</u> |
| FUNDS IN FOUNDATION YEAREND 2010 |                  | \$106,500,000      |

\*ROI of 3% for all funds due to depressed  
market conditions

## LONG TERM INVESTMENT RECOMMENDATIONS

### Assumptions:

1. We keep the annual grant funds in the Money Market Account. And divide the rest of the cash to invest between the USBank Fixed Income Account and the longer range TIFF account.
2. We continue the grant level at \$8 million per year in 2009 and 2010 as planned. If we then step it up to \$10 million a year, Robina will go out of business in about 2023 or 18 years after the first grants made in 2005.
3. If we raise the grant level to \$15 million a year, Robina would go out of business about 2018 or after being in business for 13 years.
4. Net of fees, and beyond 2010, the USBank Fixed Income Fund is projected to earn 4% per year, and the TIFF fund is projected at 8%. (It has historically earned 9%.) We are projecting a 3% annual return for 2009 and 2010 for all accounts.
5. The Money Market Fund will start each year with cash for grants for that year plus \$500,000 for the operating budget. These funds will be transferred from the USBank Fixed Income Account. The TIFF Account will remain untouched to accumulate capital until it is needed for grants, at which time funds will be transferred to USBank. Venture fund receipts will go to the USBank Fixed Income Account.
6. The \$53,000,000 cash distributed from the Estate in 2009 will be divided \$23,000,000 to the USBank Fixed Income Account, and \$30,000,000 to TIFF. The \$25,000,000 from Tartan will go entirely to TIFF, when received in 2010, or later, depending on the IRS settlement.
7. Beginning at the end of 2012, TIFF will transfer 5% of its asset value annually to the USBank Fixed Income Account, plus additional funds, as needed, to bring the annual Money Market grant funds to \$10,500,000 (or \$15,500,000). The asset drawdown from TIFF would probably be in about 2017 at the \$10 million grant level, or 2013 at the \$15 million grant level.
8. Beginning in 2010, the income from venture funds will be transferred annually to the USBank Fixed Income Account.
9. There is no provision in the financial plan for any possible recovery of the gift tax paid on the settlement sum received from Mauer. This could be \$15 to \$20 million, but will require extended legal action and legal costs to get to a final court decision as the IRS has thus far rejected the claim outright.
10. I would point out that in giving away \$10 to \$15 million a year in grants with only four grantees, puts a heavy burden on the Board to be sure the grants are sound and the results satisfactory.

To: Robina Foundation  
From: Anne Ledwein  
Date: August 10, 2008  
Re: 2008 Required Distributions

---

I have been asked to comment on the 2008 distribution requirements for Robina Foundation.

There are two factors when determining the amount of distributions for a private foundation; The first factor relates to the IRS required distributions and the second factor relates to managing the excise tax rates foundations must pay on net investment income.

#### **Required Distributions**

A Private Foundation is required to annually distribute approximately 5% of the average fair market value of the assets held by the Foundation. If a Foundation distributes more than the required amount, the excess distributions are carried over and used to offset distributions required for the next five years. If a Foundation fails to distribute the required amount by the end of the tax year, they have until the end of the next year to make the required distributions.

The foundation currently has excess distributions of \$3,371,541 available to satisfy required distributions through 2012.

**Based on the \$37,210,454 fair market value of assets held at December 31, 2007, the Foundation will be required to distribute approximately \$1,860,000 for 2008.** This amount will change if the foundation receives additional contributions during the year from the Binger Estate.

The foundation has already distributed approximately \$4,200,000. The excess distributions (and any additional 2008 distributions) will be added to the excess distributions created in prior years.

#### **Excise Tax**

A Private Foundation is required to pay an excise tax on the net investment income earned during the year. Net investment income includes interest, dividends and net capital gains (including capital gain distributions from mutual funds. It does not include net capital losses. Net Investment income is reduced by investment expenses such as advisory fees, custodial fees and other administrative expenses directly connected associated with the investments.

The excise tax rate is generally 2%; however, a Private Foundation may qualify for the reduced 1% rate. The excise tax rate is determined each year.

The 1% excise tax rate will be in effect in those years that the foundation increases the amount of distributions. In determining if a foundation has increased the level of distributions, the IRS looks at the amount of distributions compared to the average value of the assets held during the year and calculates a

distribution ratio. If the distribution ratio is higher in the current year than the average for the previous 5 years, the foundation will qualify for the reduced rate. If the foundation has been in existence for less than 5 years, the average distribution ratio for all prior years is used.

In order to continually qualify for the reduced excise tax rate, a Private Foundation will need to increase its level of distributions every year.

A private foundation should take into consideration other aspects of the foundation when determining if they want to qualify for the reduced rate. Those considerations include preserving foundation assets and "saving" the 1% rate for those years where investment income is high.

Managing the distribution ratio can be difficult because one of the main components of the calculation is the average fair market value of the assets for the entire year – which includes the December 31, 2008 values.

**Based on the \$37,210,454 fair market value of assets held at December 31, 2007 (and assuming that value remains constant), the foundation would have to distribute approximately \$4,775,000 (in both charitable disbursements and administration expenses) in order to qualify for the reduced rate in 2008.**

Through June 30, 2008, the foundation has already disbursed \$4,000,000 to charities and \$192,000 in administrative expenses). It will not be difficult for the foundation to qualify for the reduced rate in 2008.

The following is a summary of required distributions and when they were paid out:

| Year   | Required Distributions | Actual Distributions* |
|--------|------------------------|-----------------------|
| 2004   | \$142,777              | \$30,566              |
| 2005   | \$491,160              | \$488,461             |
| 2006   | \$494,032              | \$286,878             |
| 2007   | \$846,622              | \$4,515,919           |
|        |                        |                       |
| Totals | \$1,974,591            | \$5,321,824           |

\*Actual distributions include disbursements to charitable organizations as well as administration expenses. For 2005 \$303,000 of litigation expenses were included as disbursements for charitable purposes.

***To the extent that this communication and any attachments contain any federal tax advice, such advice is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code or promoting, marketing, or recommending to another person any transaction, arrangement or matter addressed herein.***

**The Robina Foundation  
Investment Policy Statement  
August 26, 2008**

**Purpose**

The purpose of this investment policy statement is to:

- Establish reasonable expectations, objectives, and guidelines in the investments of Robina Foundation's assets;
- Set forth an investment structure detailing normal allocations and permissible ranges of exposure for the Account;
- Encourage effective communication between the Robina Foundation and the Portfolio Managers (USBank and The Investment Fund for Foundations (TIFF)); and
- Create the framework for a well-diversified asset mix that can be expected to generate acceptable growth over the investment time horizon for the Foundation at a level of risk suitable to the Foundation.

**Investment Goals and Objectives**

- The assets are to be invested with the primary objective of procuring long-range annual returns equal to rate of inflation plus five percent.
- Maintenance of qualifying payout equal to roughly 5% of the asset value of the Foundation throughout the year
- The Foundation shall maintain in cash, in money market and/or checking accounts, of at least one year's worth of anticipated grant payments and administrative expenses, as determined by the Foundation's spending policy.
- The Foundation will follow the Prudent Investment Rule which calls for prudent and careful investment strategy and avoids "jeopardy investments."
- The Foundation will pay excise taxes at the lowest qualifying rate, in quarterly installments, on its net investment income.

**Asset Allocation**

| <u>Asset Category</u>                                                 | <u>Allocation</u>                |
|-----------------------------------------------------------------------|----------------------------------|
| Equities                                                              | 70% (40%-80%)                    |
| Fixed Income (bonds and money market)                                 | 30% (20%-60%)                    |
| Other (hedge funds, venture capital, private equity, and real estate) | As determined by equity manager. |

**Decision Making Process**

The Foundation's assets will be held in accounts at US Bank and TIFF. Day-to-day portfolio management decisions are at the discretion of the investment managers and will not require authorization of the President and Treasurer.

The investment managers will make investment strategy recommendations to the President and Treasurer of the Foundation. The President and Treasurer will provide authorization before any changes in investment strategy are executed.

## Performance

The performance of the Foundation's investments, computed on a total annual rate of return basis, will be measured against and should meet or exceed commonly accepted performance benchmarks over a rolling three-year period and/or full market cycle.

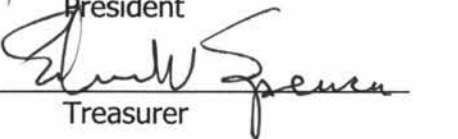
## Reporting Guidelines

The investment managers will provide performance reports to the President and Treasurer of the Foundation on a quarterly basis. Accompanying these reports will be narrative comments by the managers highlighting significant transactions, events, trends or other information the investment manager determines are noteworthy and of interest to the Board.

The investment managers shall be reviewed annually regarding performance, strategy, research, and other factors that may impact their ability to achieve the desired investment results.

This Investment Policy was voted on and approved by the Board of Directors of the Robina Foundation on Aug 26, 2008.

Signed by:

  
\_\_\_\_\_  
President  
  
\_\_\_\_\_  
Treasurer





April 24, 2008

## **Robina Foundation: Grantee Monitoring and Evaluation**

### **Suggested General Criteria for Monitoring**

- Progress against plan and timeline, significant changes to plan
- Have key personnel and other essential resources been secured/retained?
- Broader "buy-in" within institution and/or external constituencies necessary for success
- Actual income/expenditures against budget and significant changes to budget
- Any notable "leverage" of Robina grant?
- Development of distinct and measurable benchmarks for evaluation by each grantee
- The benchmarks developed should be meaningful and useful to the organization and agreed upon by key staff and organizational leadership
- For purposes of the Robina grant, the evaluation benchmarks should seek to define:
  - What will be "transformed" within the organization as a result of the project?
  - What will be the transformative effect of the project in the field/larger community?
  - *Does Robina board need to discuss the term "transformative?"*
- What is the process the organization will use to monitor its progress and make necessary changes in project direction and/or strategy?
- Sustainability of project after Robina grant concludes, if applicable

### **Yale Drama – Issues/Observations**

- Hiring of all personnel needed to implement project, especially in the area of new musical development component as proposed
- Ability to attract playwrights at level of compensation budgeted. Does level of compensation help establish a new "floor" for commissions in the field as they intend?
- Broader buy-in of regional theater community and level of interest in producing plays coming out of Yale. Actual number of productions outside of Yale.
- Ongoing progress towards development of play festival and the new Production Development Fund to be supported by Robina in year three of the grant.
- Was the Production Fund a key factor in the ability of regional theaters to produce the new plays coming out of Yale? How will they know?

### **Council on Foreign Relations – Issues/Observations**

- Management of the vast scope of the project, especially as it relates to CFR's ability to clearly articulate distinct recommendations and act in a timely manner to seize opportunities for policy change (they noted that bundling too many recommendations together in the past had hurt their effectiveness).
- The degree to which policy recommendations reflect/incorporate the views and preferences of non-US interests in order to increase viability in the international arena
- Degree to which the project examines the role of non-state actors and develops strategies that are widely accepted
- Effectiveness of marketing plan to promote CFR recommendations to existing constituencies
- Demonstration by CFR that they have broadened their outreach to include activist groups that could help promote policy recommendations



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From: SPatrick@cfr.org [Add to Address Book](#)  
To: gaamoth@robinafoundation.org  
CC: jms\_pc@msn.com, shelm@cfr.org, abaker@cfr.org, SGilbert@cfr.org  
Date: Tuesday, July 29, 2008 3:26:36 PM  
Subject: CFR Program Benchmarks for FY09  
[Agenda and benchmarks FY09 final.pdf](#)

Dear Gordon:

I hope that you have been having an enjoyable summer.

In anticipation of your upcoming Board meeting, I wanted to provide an overview of the agenda and benchmarks we have developed for FY09 for the Program on International Institutions and Global Governance. We are indebted to you and to the other members of the Robina Foundation's Board for placing your confidence in us.

Please let me know if you have any questions or comments.

With warm regards.

Yours sincerely,

Stewart

---

Dr. Stewart Patrick  
Senior Fellow and Director  
Program on International Institutions and  
Global Governance  
Council on Foreign Relations  
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## **Program on International Institutions and Global Governance**

### **Agenda and Benchmarks for Fiscal Year FY09**

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The Program on International Institutions and Global Governance is designed to improve U.S. and international understanding of the critical global challenges and opportunities of the twenty-first century and to offer concrete proposals for more effective multilateral cooperation. It seeks to assist the architects of U.S. foreign policy, as well as their counterparts in other governments and in global and regional institutions, in ensuring that today's international institutions are more closely tailored to global realities, capable of providing critical global public goods, and consistent with long-term U.S. national interests. During Fiscal Year 2009, the Council will use \$1.9 million of its generous grant from the Robina Foundation to advance these ambitious aims. Funding from the Foundation will support the work of at least fifteen members of its Studies Program working directly on issues of global governance, as well as permit the Council to launch a wide array of programmatic activities on specific global challenges, regional institutions, and international organizations.

#### **Programmatic Activities and Benchmarks for FY09**

During its current fiscal year (which began on July 1, 2008), the Council will undertake a wide range of programmatic activities on particular global challenges and on specific regional institutions. The activities of core program staff will include:

- (1) mapping and evaluating the current institutional architecture of multilateral cooperation;
- (2) hosting a roundtable series on proposed frameworks for world order and U.S. policy responses;
- (3) establishing a web presence to make the Council a center of excellence on global governance;
- (4) hosting the first in a series of annual conferences in New York in spring 2009.

The Director will also undertake one specific regional initiative, collaborating with Paul Stares, Director of the Council's Center for Preventive Action, to explore U.S. policy options to strengthen the effectiveness of regional and sub-regional peace and security institutions in Africa. In addition, the Director anticipates releasing one book (currently with the publisher) and finishing another full-length manuscript during 2009.

In parallel with these core staff initiatives, other full-time and adjunct members of the Studies Program will use Robina funding to pursue a range of issue area and regional activities anticipated in the original application to the Foundation. As elaborated below, these initiatives will address topics including: the future of NATO on its 60<sup>th</sup> anniversary; multilateral security cooperation in Northeast Asia; a potential coalition of major emitters to combat climate change; voluntary codes of conduct for managing natural resource revenues; U.S. foreign policy and the rule of law; the US and the International Criminal Court; the future of maritime governance; global health priorities; and energy security in the Western Hemisphere.

The agenda outlined below for FY09 will place the Council in a strong position to meet the ambitious objectives set forth in its initial proposal. The envisioned activities cover many of the global and regional challenges we identified in that document, and the pace of meetings and products we have set for FY09 will likely exceed what we promised the Foundation.

### *Activities of Core Staff*

The Director of the International Institutions and Global Governance program and his staff will focus their activities in FY09 on:

- *Launch of International Institutions and Global Governance Web Page.* The program will work with David Kellogg and his colleagues at CFR.org to develop and launch a “destination application page” (DAP) for the International Institutions and Global Governance program. This page will provide a convenient platform for showcasing several of the program’s products, including the envisioned global governance “scorecard” (see next bullet); a series of “backgrounders” on specific global challenges; and publications and commentary by core staff and other Council fellows on pertinent issues. The page will exploit a range of media, including web links to core documents and institutions and video clips of Council staff discussing particular challenges.
- *Mapping and Evaluating Existing Institutions of Global Governance.* The Director will supervise the creation of a user-friendly “Scorecard” of current institutions of global governance. For each global issue area (e.g., nonproliferation, global health), the matrix will identify (a) the importance of this issue for the United States; (b) the scope and mandate of the main treaties, regimes and organizations governing state conduct in this area; (c) the strengths and weaknesses of these frameworks in terms of effectiveness, participation, legitimacy, and other criteria; (d) and the current attitude of the United States toward these frameworks. Each issue area will be linked to a short (3,000 word) “backgrounder” providing more detailed factual information. The scorecard could be updated on an annual basis.
- *Roundtable on the United States and the Future of Global Governance.* The Director will hold a monthly series of meetings focused on core global governance challenges, including proposals for fundamental institutional reform. Topics will include reform and expansion of the G8; overhaul of the UN Security Council; creation of an Alliance of Democracies; the adaptation of U.S. sovereignty to a global age; trade-offs between formal institutions and ad hoc coalitions; and the domestic and legislative preconditions for sustained U.S. multilateral engagement. Discussions will be focused on short commissioned background papers.
- *U.S. Policy toward African Peace and Security Institutions.* The Director will collaborate with Paul Stares, the Director of the Center for Preventive Action, in assessing the capabilities of new African regional and sub-regional institutions, including the African Union and ECOWAS, to prevent and respond to violent conflict on the continent. This research and policy agenda will culminate in a Council Special Report examining the role of the United States (including the new Africa Command), as well as the UN, EU, and NATO, in bolstering these new institutions. Robina funding will support travel to Addis, Abuja, Djibouti, and AFRICOM headquarters.
- *Annual Conference on International Institutions and Global Governance.* The program will inaugurate an annual conference series in spring (likely May) 2009, showcasing the work of the Studies Program and outside experts on matters of global governance. The Director is currently exploring possible themes and issue areas likely to merit particular attention.

- *Book Launch and Research.* The Director anticipates launching one book in early 2009 (currently in press) on the origins and evolution of American multilateralism during 1940-1950. He also hopes to finish by late 2008 a second manuscript on the subject of weak states, global threats, and international security, to be published by autumn 2009.
- *International and Domestic Travel and Consultations.* The Director and colleagues anticipates beginning consultations with counterpart institutions, government officials, and non-state stakeholders in Europe, Asia, Latin America, Africa and the Middle East, as well as the United States, during FY09.

### *Activities of Other Studies Fellows*

Beyond launching these core activities, the Program will use Robina funding to support specific programmatic activities that promise to advance U.S. understanding of and international policy responses to pressing areas of global governance. For FY09, the program has identified the following ten regional and issue area priorities as ripe for the investment of Robina resources:

- *NATO at 60: The Future of the Western Alliance.* The Council will hold a symposium in Washington in spring 2009 to mark the sixtieth anniversary of NATO. This gathering, and related publications, will address the alliance's appropriate place in U.S. national security policy and role in the new threat environment; draw lessons of Afghanistan for NATO's involvement in out of area operations and irregular warfare; and explore the evolving relationship between NATO, the EU, and Russia. Elizabeth Sherwood-Randall, Charles Kupchan, James Goldgeier, Stephen Sestanovich, and Stewart Patrick will participate in this event and a subsequent meeting in Europe in late 2009.
- *An Emerging Security Architecture in Northeast Asia?* Robina funding will permit the Council to host a workshop of prominent "next generation" scholars and policymakers from China, Japan, South Korea, Russia and the United States to discuss potential multilateral frameworks for cooperative security in this critical sub-region. Besides travel, Robina funding will support modest honoraria for commissioned papers on critical security challenges. Senior Fellow Sheila Smith will lead this initiative, including a subsequent workshop in Asia in FY09.
- *A Major Emitters Coalition to Combat Climate Change.* Building on its recent Task Force Report, the Council will explore methods of practical cooperation among the handful of countries responsible for the lion's share of greenhouse gas (GHG) emissions, as an adjunct to UN-focused negotiations involving all of the world's countries. The goal will be to drive tangible GHG reductions among coalition members without undermining the parallel UN track. Senior Fellow Michael Levi will lead this effort, with support from Robina funding.
- *Codes of Conduct for Natural Resource Exploitation.* The Council will evaluate the track record of recent, innovative global governance tools designed to fight corruption and reduce violent conflict in the developing world: corporate and governmental codes of conduct for transparent revenue management in the exploitation of natural resources. The resulting Council Special Report will examine the efficacy of the Extractive Industries Transparency

Initiative, the Kimberley Process for Conflict Diamonds, and similar efforts. Sebastian Mallaby, Senior Fellow and Director of the Center for Geoeconomic Studies, will lead this initiative in consultation with the International Institutions and Global Governance Program.

- *U.S. Foreign Policy and the International Rule of Law.* This year-long roundtable series involving a diverse U.S. officials and legal scholars will examine: the emergence of new legal norms, (including governing the use of force); the scope and intrusiveness of emerging international law, including its impact on U.S. sovereignty; the implications of expanding international courts and tribunals; and the challenges of restoring America's traditional leadership in international legal development. Adjunct Fellow Matthew Waxman will lead this series.
- *The United States and the International Criminal Court.* This research effort, culminating in a Council Special Report, will examine prospects for cooperation between the United States and the ICC, short of actually becoming party to the treaty. Seeds for such a pragmatic approach have already been planted with the U.S. vote on the Security Council to refer atrocities in Darfur to the ICC. Adjunct Fellow Lee Feinstein will conduct this study.
- *Strategic Ocean Governance.* The world faces a crisis of governance in the ocean commons, which cover three quarters of the earth's surface. This Council initiative will address five critical components of any strategic U.S. oceans policy: countering transnational threats to U.S. security, including WMD proliferation, piracy, and human smuggling; managing commercial uses of the ocean, including oil and gas production, deep seabed mining, and renewable energy; mitigating conflict over the Arctic as global warming proceeds; improving stewardship of the living marine environment, including management of fisheries and stemming pollution; and responding to conflict and humanitarian dislocation from ocean degradation and climate factors. Visiting Fellow Scott Borgerson will lead this initiative.
- *Global Health Priorities for the New Administration.* This workshop, to be held in September 2008, will bring together senior UN and World Bank officials and prominent health and development experts to take stock of advances in global health governance and service delivery during the administration of George W. Bush and the priorities that should guide his successor. Senior Fellow Laurie Garrett will organize and lead this effort.
- *Energy Security in the Western Hemisphere.* Building on its recent Task Force Report on US-Latin American Relations, the Council intends to explore opportunities for deepening multilateral cooperation within the hemisphere on critical issues. In FY09, the Council will partner with think tanks in Brazil (CEBRI) and Canada (CIGI) in a series of three meetings to examine regional cooperation on energy security. Future work will examine multilateral initiatives to combat transnational threats, including crime and illegal migration. Fellow Shannon O'Neil will steer this initiative.

## **Benchmarks**



We will assess the performance of the program in three dimensions—outputs, outcomes and impact. For FY09, we anticipate that these will include:

Core Staff:

- Completion of prototype for Global Governance Scorecard, based on consultation, research
- Introduction of a roundtable series on the U.S. and the Future of Global Governance (no fewer than six meetings for FY09)
- Launch of book on the origins and evolution of American multilateralism.
- Completion of volume on weak states, global threats and international security
- Publication of journal articles, op-eds and other publications and appearances and citations in policy and popular media print
- Launch of the International Institutions and Global Governance web page
- Annual Conference on International Institutions and Global Governance
- Completion (or near-completion) of Council Special Report on the United States and African Peace and Security Institutions
- Consultations and requests for formal and informal briefings to U.S. government agencies, Congress, multilateral institutions and other bilateral agencies on global governance issues
- Presentations and addresses by program staff, which we will track as part of our annual reporting to the foundation
- Requests by stakeholder agencies and organizations for follow-on research, activities and presentations on subjects relevant to the program
- Input to decisions by executive branch, Congress, foreign nations, and international organizations

Other Council Staff

- Successful completion of anticipated conference on NATO at 60, including publication (or near-completion) of Council Special Report on this topic by Elizabeth Sherwood-Randall
- Completion of Workshop on Security Architecture in Northeast Asia, including publication on Council web site (and potentially other venues) of workshop background papers
- Completion of Roundtable series and Special Report on Strategic Ocean Governance
- Holding of a meeting on Global Health Priorities for the next U.S. administration
- Holding of two to three meetings on a Major Emitters Coalition to Combat Global Climate Change, including officials of relevant member state governments
- Hosting of and participation in regional meetings on energy security in the Americas
- Publication of Council Special Report on Voluntary Codes for Natural Resources
- Publication of a Council Special Report on U.S. Policy toward the ICC
- Publication of journal articles, op-eds and other publications and appearances and citations.
- Consultations and requests for formal and informal briefings to U.S. government agencies, Congress, multilateral institutions and other bilateral agencies on select issues
- Requests by stakeholder agencies and organizations for follow-on research, activities, and presentations on subjects relevant to the program
- Input to decisions by U.S. government, foreign nations, and international organizations

# COUNCIL ON FOREIGN RELATIONS

WASHINGTON OFFICE • 1779 MASSACHUSETTS AVENUE, NW • WASHINGTON, DC 20036-2109

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[www.cfr.org](http://www.cfr.org)

*The David Rockefeller Studies Program*

Stewart Patrick  
*Senior Fellow and Director*  
*Program on International Institutions*  
*and Global Governance*

July 7, 2008

Dr. Gordon Aamoth  
President  
Robina Foundation  
80 South 8<sup>th</sup> Street  
Suite 4900  
Minneapolis, MN 55402

Dear Dr. Aamoth:

I am writing to describe the activities undertaken with the Robina Foundation's initial planning grant to the Council on Foreign Relations, as well as to provide you with a status report on the program on International Institutions and Global Governance, which the Foundation's generous funding has made possible.

As you will recall, the Foundation in January 2007 extended to the Council an initial grant of \$50,000 to define the scope and content of an ambitious new program addressing some important issues outside of the Council's regular research agenda, which was of significant interest to both the Council and the Foundation. After considerable discussion and debate among Council staff, directors and members, we decided to pursue an agenda of policy research and engagement on the multilateral management of global issues. The rationale for this initiative was a broad recognition that the institutional architecture of global governance is inadequate to meet many of the challenges posed by globalization.

This planning grant permitted the Council to hire me as an independent consultant for several months, to take the lead in drafting a proposal for a multi-year program on International Institutions and Global Governance. In this capacity, I worked closely with Vice President and Director of Studies Dr. Gary Samore and his colleagues to define the scope and content of this cross-cutting initiative.

Our activities during this planning period included surveying the landscape of existing academic and think tank work in the field of global governance; engaging established experts in academia, government service, and international agencies on the strengths and weaknesses of current international institutions; and soliciting the ideas of Council Fellows on those issue areas and regions where the challenges of institutional reform are most compelling. Council President Richard Haass himself was deeply engaged in these deliberations and provided extensive comments on successive drafts of the ultimate proposal to the Robina Foundation. The attached financial statement provides a breakdown of the uses of this planning grant.

On January 28, 2008, as you will recall, the Council had an opportunity to make a formal presentation of its grant request to the full Robina Board. We were delighted with your subsequent decision to fund the proposed program on International Institutions and Global Governance, at the level of \$2 million per year for three (and provisionally five) years. I was particularly delighted, since the Council then hired me as a Senior Fellow to direct the initiative.

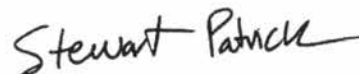
Since joining the Council full-time on April 30, 2008, I have been busily engaged in hiring staff, determining funding priorities, and planning core programmatic activities for this year and beyond. On the personnel front, we have recently hired a research associate and will shortly be bringing on board a deputy director to provide managerial and administrative support. Beyond supporting core program staff, the Robina Foundation's grant will provide partial salary support for several other Fellows focused on research and policy engagement on issues of global governance.

I envision carrying out a wide range of programmatic activities for fiscal year 2009 (which began for the Council on July 1). These include among other things producing a "scorecard" of current international institutions; launching a dedicated program web page on CFR.org; conducting research and travel on the future of African peace and security institutions; holding a roundtable series on the United States and the future of global governance; and hosting a spring 2009 conference on pressing global governance challenges for the new U.S. administration.

In addition to funding the activities of core program staff, the grant will support work by other Council Fellows on specific global and regional challenges. For the upcoming year, we envision supporting research, travel, meetings, and consultation in several areas, including among others: the future of multilateral security cooperation in Northeast Asia; the role and mission of the NATO alliance on its 60<sup>th</sup> anniversary; cooperation within the Western Hemisphere on energy security and transnational threats; prospects for a coalition of major emitters to address global climate change; and the future of ocean governance. We look forward to providing you with additional detail on these activities through annual update reports. In addition, we intend to report back to you by August 1<sup>st</sup> with our initial thoughts on benchmarking our progress.

On behalf of Council President Richard Haass and Director of Studies Gary Samore, I would like once again to thank you and the Robina Foundation for putting their faith in the Council with this generous grant. We look forward to being in regular contact with you and to relying on your participation and advice as we develop this ambitious initiative.

Yours sincerely,



Stewart Patrick



# COUNCIL ON FOREIGN RELATIONS

## Program on International Institutions and Global Governance

### Financial Statement

The Robina Foundation

January 1, 2007 - June 30, 2008

|                             |          |
|-----------------------------|----------|
| Total Grant                 | \$50,000 |
| Balance as of June 30, 2008 | \$0      |

|                 | <u>Actual Expenses<br/>(1.1.07 - 12.30.07)</u> | <u>Actual Expenses<br/>(1.1.08-6.30.08)</u> |
|-----------------|------------------------------------------------|---------------------------------------------|
| Stipend         | \$10,000                                       | \$15,000                                    |
| Travel Expenses | 0                                              | \$576                                       |
| Personnel       | <u>0</u>                                       | <u>\$24,424</u>                             |
| Total Costs     | \$10,000                                       | \$40,000                                    |

Funds from the planning grant supported Dr. Patrick's research and preparation of the proposal for the multi-year Program on International Institutions and Global Governance and the associated travel expenses. Funds also supported the time of those CFR senior staff members Dr. Stewart worked with to prepare the full proposal, specifically President Richard Haass and Director of Studies Gary Samore.

**CONTACT:** Gila Reinstein  
Or Kathy Colello

203-432-1325  
203-432-4854

[gila.reinstein@yale.edu](mailto:gila.reinstein@yale.edu)  
[kathleen.colello@yale.edu](mailto:kathleen.colello@yale.edu)

**For Immediate Release:** July 24, 2008

***Yale Law School Receives \$3 Million Gift from the Robina Foundation  
To Support Robina Foundation Human Rights Fellowship Initiative***

**New Haven, Conn.**— Yale Law School will expand the next generation of human rights leaders with the help of a \$3 million gift from the Robina Foundation. The gift, to be administered over the next three years, will create the Robina Foundation Human Rights Fellowship Initiative at Yale Law School, which will provide support for human rights leaders at all stages of their careers, from J.D. students to senior-level fellows.

The Robina Initiative will meet the intense interest students have in human rights and their need for financial support to pursue human rights careers. It will also foster the work of human rights advocates by providing opportunities for them to spend time in residence at Yale Law School.

“Investing in the development of human capital is a critical, but usually overlooked, step toward ensuring the successful future of the human rights movement worldwide,” said Dean Harold Hongju Koh. “The Robina Foundation Human Rights Fellowship Initiative here at Yale Law School will seek to fill that gap by educating future leaders at all levels and fields of human rights work.”

Through the Robina Human Rights Fellowship Initiative, Yale Law School will make financial support available as:

- **Student Scholarships**—financial aid to offset the tuition of students committed to human rights careers;
- **Summer Human Rights Fellowships**—living stipends and travel funds available for first- and second-year law students to spend the summer working in human rights-oriented jobs.
- **Postgraduate Fellowships**—funding for Yale Law School alumni to begin their human rights practice immediately after law school;
- **Fellows in Residence**—opportunities for scholars, clinicians, government servants, and practitioners to take time away from the intensity of their international human rights careers to explore and contribute new ideas in the stimulating intellectual community of Yale Law School.

The result of these efforts, said Dean Koh, “will be an expanding network of superbly trained human rights scholars, practitioners, and teachers capable of making a difference in all varieties of human rights struggles.”

Gordon Aamoth, president of the Robina Foundation, said, “James Binger, a Yale alumnus and prominent Minneapolis businessman and philanthropist, established the

Robina Foundation funded by his estate with the purpose of supporting projects that are transformative that will positively affect our society and the world we live in. We believe the Robina Human Rights Fellowship at Yale Law School will do this with a lasting legacy.”

Yale Law School has long been committed to human rights education and advocacy. For decades, its Orville H. Schell Jr. Center for International Human Rights and Allard K. Lowenstein International Human Rights Clinic have educated and provided valuable experience to top-flight students passionate about human rights promotion, hired academic and clinical educators with the theoretical and practical knowledge to train students in the practices most likely to yield human rights improvements, and created a community of alumni committed to a culture of encouraging public service. An array of fellowships, including the Robert L. Bernstein Fellowships in International Human Rights, provides opportunities for current students and graduates to deepen their experience. By operating in partnership with the Schell Center, the Robina Initiative will build on the Center’s reputation, allowing the Law School to expand its impact on human rights across the world.

The Robina Foundation, a Minnesota-based private grantmaking foundation, seeks to positively affect critical social issues by encouraging innovation and financially supporting transformative projects of its four institutional partners: Abbott Northwestern Hospital in Minneapolis, The Council on Foreign Relations, Yale University, and the University of Minnesota Law School. These partners were selected by the Foundation’s founder, James H. Binger, a 1938 alumnus of Yale College who passed away in 2004 at age 88. Mr. Binger was a noted philanthropist, theater entrepreneur, and former chairman of Honeywell. Through the Foundation, his vision, sense of adventure and generosity, and commitment to creative endeavors endure.

###

YALE UNIVERSITY

OFFICE OF THE PRESIDENT

105 WALL STREET, PO BOX 208229  
NEW HAVEN CT 06520-8229

July 1, 2008

Gordon Aamoth, M.D.  
Robina Foundation  
4900 IDS Center  
80 South 8th Street  
Minneapolis, MN 55402

Dear Gordon:

I am delighted to learn of the recent payment of \$1,000,000 from the Robina Foundation to Yale Law School toward the Foundation's commitment of \$3,000,000 for the Robina Fellowship Initiative. On behalf of the University, I am deeply grateful for this very generous support.

The advancement of human rights around the world and the strengthening of institutions that protect these rights have been core priorities for Yale Law School under Dean Koh's leadership. The Robina Fellowship Initiative will enable Dean Koh and his colleagues to foster the intellectual development of the full spectrum of students, scholars, and practitioners with interests in the field of international human rights.

My colleagues at Yale Law School and I are excited about the opportunities that the Robina Foundation has created with this grant. I look forward to following the Robina Fellowship Initiative as it unfolds, and to continuing and strengthening the relationship between the Robina Foundation and Yale.

With my best regards,

Sincerely yours,

*Rich*

Richard C. Levin

RCL:mg

May 27, 2008

Dean Harold Hongju Koh  
Yale Law School  
P.O. Box 208215  
New Haven, Connecticut 06520-8215

Dear Dean Koh:

I am pleased to inform you that the Board of Directors of the Robina Foundation has recently approved a grant in the amount of \$3 million to the Yale School of Law for the Robina Fellowship Initiative. The purpose of the grant is to support the various fellowships and activities presented in your proposal dated May 14, 2008. The Board of Directors of the Foundation is pleased to invest in the development of human rights leaders at various levels of their education and experience and is hopeful the return will be significant.

The total grant amount of \$3 million will be paid in equal annual installments beginning in 2008 and concluding in 2010. Payments will be made via wire transfers to the bank account designated by Yale University. At your earliest convenience please send wire instructions to Nancy Gilberg, Administrative Consultant at: [ngilberg@robinafoundation.org](mailto:ngilberg@robinafoundation.org).

Please plan to provide written progress reports to the Foundation on an annual basis. These reports should include both a narrative and financial update on the actual use and impact of the grant funds. In addition to annual reports, the Foundation asks that Yale initiate contact during interim reporting periods to inform us of any significant issues such as changes in key personnel, a project budget reallocation of greater than 10%, or a change in the scope of the project that may impact its ability to achieve desired outcomes.

The Board is specifically interested in the following information regarding the Fellowship Initiative. Please plan to address these questions in the periodic annual reports required.

- Will the Law School seek additional funds to sustain the Robina Fellowship Initiative after the three year grant period? If so, what are Yale's preliminary thoughts on possible sources of future funds?
- How will Yale measure the impact of the Fellowship Initiative? How will you know if the initiative has achieved the desired results of positively impacting both individual recipients and the larger field of work in the arena of human rights? What types of measurement tools and strategies would be able to provide more than anecdotal information about the impact of the initiative?

As part of its ongoing programmatic work, the Foundation may conduct its own evaluation of the initiative at anytime during the grant period. We will inform you in advance if we wish to conduct an independent evaluation and ask for your cooperation.

Again, the Robina Foundation is pleased to support the Robina Fellowship Initiative at Yale Law School. We wish you all the best as you move forward and look forward to staying abreast of your work.

Sincerely,

Gordon Aamoth, President  
Robina Foundation

cc: Richard C. Levin, President  
Inge T. Reichenbach, Vice President, Development  
Kenna Barrett, Director of Corporate and Foundation Relations

YALE UNIVERSITY

OFFICE OF THE PRESIDENT

105 WALL STREET, PO BOX 208229  
NEW HAVEN CT 06520-8229

June 18, 2008

Mr. Gordon Aamoth  
Robina Foundation  
c/o Faegre & Benson LLP  
90 South 7<sup>th</sup> Street  
Minneapolis, MN 55402-3901

Dear Gordon:

I know that James Bundy has shared with you the press release on the Robina Foundation's gift to establish the Center for New Theatre at Yale. I thought you might also enjoy a glimpse — in the form of the most recent issue of the *Yale Bulletin & Calendar* — of the enthusiastic reception the announcement is receiving among the wider Yale community.

The feature on page five of the enclosed *Bulletin* nicely demonstrates how vital the Robina Foundation support will be to continuing the tradition of leading-edge theater production and development at Yale Drama. The accompanying sidebar on the upcoming season at the Yale Rep beautifully illustrates how the New Theatre initiative will contribute to, and build upon, a flourishing history of artistic innovation here on campus.

Many thanks, once again, for your instrumental role in making this exciting endeavor possible!

With warmest regards,

Sincerely yours,



Richard C. Levin

RCL:mg

Enclosure



## Gift of \$2.85 million to fund Yale Center for New Theatre

The Yale School of Drama and Yale Repertory Theatre have received a \$2.85 million gift from the Robina Foundation to establish the Yale Center for New Theatre.

Through the new center, the Yale Rep will substantially increase its annual commissions of new plays and musicals, and support these commissions through all stages of artist-driven development, including residencies, readings, workshops and full productions.

The Yale Center for New Theatre will also facilitate playwrights' residencies as lecturers at the School of Drama, and the development of curriculum in writing for musical theatre at Yale. Paula Vogel, who was recently appointed the Eugene O'Neill Professor (adjunct) and chair of playwriting at the School of Drama, will also serve as playwright-in-residence at the Yale Rep.

The gift includes a \$600,000 production fund to be administered by the Yale Center for New Theatre as support provided to other not-for-profit theaters producing world premiere or second productions of plays commissioned by Yale Rep through the center.

The Yale Center for New Theatre will be overseen by James Bundy, dean of the School of Drama and artistic director of the Yale Rep, and Jennifer Kiger, associate artistic director of the Yale Rep and director of its new play program.

"For more than four decades, the Yale Repertory Theatre has developed and produced new work by some of the most vital and important voices in contemporary drama," said President Richard C. Levin. "This generous gift from the Robina Foundation is a direct investment in the future of the American theater, and ensures that the

Yale Rep will continue to have a significant and lasting impact on the development of new work for the stage."

Bundy noted: "The Yale Center for New Theatre will provide artists with the time and resources to create new work, and build a larger community of playwrights, composers, lyricists and directors promoting professional training in every discipline of the theater. We are particularly pleased to extend meaningful support to emerging playwrights through commissions and production opportunities that help them reach a wider audience."

Gordon M. Aamoth, president of the Robina Foundation, said: "The Robina Foundation is pleased to participate in Yale School of Drama and Yale Repertory Theatre's commitment to providing playwrights with the means to actively pursue careers in the theater at a time when more lucrative forms of media may lure them away. Supporting the creation of new work will help maintain this creative wellspring. Supporting them in a university environment, in particular, offers a unique and especially creative venue for developing plays and for nurturing their talents and imagination."

The Robina Foundation, a Minnesota-based private grantmaking foundation, seeks to positively impact critical social issues by encouraging innovation and financially supporting transformative projects of its four institutional partners which were selected by the foundation's founder, James H. Binger. They are: Abbott Northwestern Hospital and the University of Minnesota Law School in Minneapolis, Minnesota; The Council on Foreign Relations, New York City; and Yale University.

A champion of new work, the Yale Rep has produced well over 100 world, American and regional premieres — including two Pulitzer Prize winners and four other nominated finalists — by emerging and established playwrights. Eleven Yale Rep productions have advanced to Broadway, garnering more than 40 Tony Award nominations and eight Tony Awards, and the Yale Rep itself is the recipient of the Tony Award for Outstanding Regional Theatre.

In its 42-year history, Yale Repertory Theatre has produced the world premieres of plays by David Adjmi, Roberto Aguirre-Sacasa, Lee Blessing, Christopher Durang, Jules Feiffer, Athol Fugard, Marcus Gardley, Kama Ginkas, John Guare, Albert Innuarato, Walton Jones, Adrienne Kennedy, Arthur Kopit, Sunil Thomas Kuruvilla, Wendy MacLeod, Julie McKee, Terrence McNally, Richard Nelson, Suzan-Lori Parks, David Rabe, Keith Reddin, José Rivera, Sarah Ruhl, Sam Shepard, William Styron, Derek Walcott, August Wilson and Doug Wright, among many others.

Current Yale Repertory Theatre commissions include "Notes from Underground," a new play by Robert Woodruff and Bill Camp adapted from Fyodor Dostoevsky's novel, which will have its world premiere at Yale Rep in March 2009; as well as original plays by Adjmi, Hilary Bell, Gardley, Amy Herzog, Naomi Iizuka, Rolin Jones, Elizabeth Meriwether, Octavio Solis, Kate Walat, Anne Washburn and Marisa Wegrzyn; and a new musical by playwright Adam Bock and composer Todd Almond based on Shirley Jackson's "We Have Always Lived in the Castle."

## Classic works and premieres will highlight 2008-2009 season at the Yale Rep

The world premiere of a play based on Dostoevsky's revolutionary novel "Notes from Underground" and a re-staging of Arthur Miller's classic drama "Death of a Salesman" will be among the featured works in the Yale Repertory Theatre's 2008-2009 season.

The season line-up is as follows:

"**Passion Play**" by Sarah Ruhl; directed by Mark Wing-Davey, Sept. 19-Oct. 11. A trilogy of plays performed in one evening, this work transports audiences across three centuries to explore the power of performance to transform ordinary sinners into saints and world leaders into theatrical icons.

"**Happy Now?**" by Lucinda Coxon; directed by Liz Diamond, resident director at the Yale Rep, Oct. 24-Nov. 15. The work, making its American premiere, offers

a comic take on contemporary life and how to survive it.

"**Rough Crossing**" by Tom Stoppard; directed by Mark Rucker. Nov. 28-Dec. 20. This work about the problem-riddled making of a brand new musical comedy features original music composed by André Previn.

"**Lydia**" by Octavio Solis; directed by Juliette Carrillo, Feb. 6-28. This will be the East Coast premiere of Solis' work about a Mexican immigrant family caught in a web of dark secrets.

"**Notes from Underground**" by Fyodor Dostoevsky, as adapted by Robert Woodruff (who is the director) and Bill Camp (who appears in the play), March 20-April 11. The play focuses on a former government official who has withdrawn from a corrupt society and is waging his own personal war on everything — and

everyone — around him.

"**Death of a Salesman**" by Arthur Miller; directed by James Bundy, dean of the School of Drama and artistic director of the Yale Rep. Being presented at the Yale Rep for the first time, Miller's Pulitzer Prize and Tony Award-winning masterpiece will feature Charles S. Dutton as Willy Loman.

The Yale Rep offers a variety of packages for audiences to enjoy the entire season. Subscriptions, four- and six-ticket passes, and group sales are now available online at [www.yalerep.org](http://www.yalerep.org); by phone at (203) 432-1234; and in person at the Yale Rep box office, 1120 Chapel St. (at York) Monday-Friday 10 a.m.-5 p.m., Saturday noon-5 p.m. and until 8 p.m. on all performance evenings. Tickets to individual plays will be available beginning on Sept. 2.





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## ASSISTANCE PROVIDED TO THE AUDITOR BY THE FOUNDATION

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1. Responsible executive and administrative consultants will be available during the audit to assist the firm by providing information, documentation, and explanations, as requested.
2. The Foundation will prepare and mail confirmation letters, with responses to be directed to the audit firm.
3. The Foundation consulting team, working with its external accounting firm, will gather all requested financial records, schedules and underlying documentation as requested by the audit firm preceding commencement of fieldwork.
4. The Foundation will provide the auditor with reasonable workspace, desk, chair, and access to phone, copier, and fax.
5. Report preparation, editing, and printing shall be the responsibility of the auditor.

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## AUDITOR QUALIFICATIONS

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Please include the following information in your proposal.

I. **Firm Profile**

- A. Resources available
- B. Office capabilities and areas of expertise
  1. Audit staff size
  2. Nonprofit audit staff size
  3. Staff experienced in nonprofit tax issues and specific experience in auditing private grant-making foundations,
- C. Experience
  1. Proposed staff members' experience with other nonprofit institutions
  2. Proposed staff members' experience with other private grantmaking foundations
  3. Three relevant references: contact names, phone numbers, and brief description of services provided
- D. Professional affiliations
  1. A listing of memberships in local and national professional organizations
- E. Peer review
  1. A copy of the results of the firm's most recent peer review

II. **Service Team**

- A. Proposed staffing – engagement partner, supervisory staff, and field staff with a clear statement of each individual's role and responsibility
- B. Resumes of all proposed staff
- C. Continuity of services plan to ensure consistent quality and service delivery in the event of staff promotion, rotation or turnover

III. **Service Strategy**

- A. Description of the firm's proposed audit process and plans for a smooth audit transition
- B. Complete timetable of performance of work
- C. Statement of how you expect to interact with Foundation management
- D. Approach to delivery of the services requested

IV. **Fees**

- A. Yearly fee for annual audit and all related services. This should be an all-inclusive fee.
- B. Description of preferred payment schedule

- C. Hourly rates that would apply to any special or non-recurring work, by staff level
- D. Out of pocket expense policy
- E. Policy regarding routine support calls that do not involve extensive research

***Fees should be quoted for a three-year period.***

***January 1, 2009 through December 31, 2011***

Our intent is to enter into a three-year engagement with the selected firm, subject to annual evaluation for satisfactory performance. We reserve the right to terminate the engagement at any point if performance standards are not met. Should this occur, the Foundation will be responsible only for actual charges incurred to date.

***Deadline for proposal submission is August 29, 2008. Please send your completed proposal to:***

**Jean Szevich, Managing Consultant**

**Robina Foundation**

**80 South 8<sup>th</sup> Street, Suite 4900**

**Minneapolis, Minnesota 55402**

**612-333-2313**

**Selection Timeline:**

It is anticipated that the Foundation will select an auditing firm by October 15, 2008.

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## THE ROBINA FOUNDATION

### REQUEST FOR PROPOSALS - AUDIT SERVICES

JULY 2008

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#### LIST OF ANNUAL SERVICES REQUESTED

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1. Annual audit of the Robina Foundation, a private grant-making foundation, based in Minneapolis, Minnesota. The Foundation, established in 2004, seeks to positively impact critical social issues by encouraging innovation and financially supporting transformative projects of its four institutional partners. These partners, selected by the Foundation's founder, James H. Binger, are: Abbott Northwestern Hospital, Minneapolis, MN; The Council on Foreign Relations, New York, NY; University of Minnesota Law School, Minneapolis, MN; and Yale University, New Haven, CT. The total annual operating and grantmaking budget for the foundation in 2008 is roughly \$8 million. The total assets of the Foundation at this time are approximately \$33 million.
2. Testing of accounting controls and procedures.
3. Preparation of audited financial statements, including:
  - Statement of Financial Position (balance sheet)
  - Statement of Activities and Changes in Net Assets
  - Statement of Functional Expenses
  - Statement of Cash Flows
  - Notes to Financial Statements, as necessary
4. A formal opinion regarding the Foundation's fair presentation of its financial statements in accord with U.S. Generally Accepted Accounting Principles.
5. Preparation of a separate Management Letter noting any areas of concern with regard to the Foundation's accounting procedures or controls, as well as suggested pro-active areas for consideration, such as select Sarbanes-Oxley measures not otherwise applicable to nonprofit organizations.
6. Attendance at the following meetings to present and discuss the audit results:
  - Conference with management, if requested
  - Board annual meeting
7. Timing of Audit:
  - Fiscal year-end is December 31.
  - Before the end of December, provide an audit preparation list to Foundation staff outlining requirements for confirmation letters, documents to be reviewed, fieldwork schedule, etc.
  - Conference with management and Audit Committee Chair, prior to start of field work.
  - Draft report presented to management and Audit Committee Chair by June 30, 2009.
  - Draft report presented to full Board of Directors at its annual meeting in August 2009.
  - Final copies of audited financial statements and management letter delivered, following Board approval.
    - 10 bound copies of the audited financial statements
    - 1 unbound copy of the audited financial statements, suitable for copying
    - PDF file of the audited financial statements
    - 3 copies of the management letter
    - PDF file of the management letter



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**From:** Crosby, Thomas M. [Add to Address Book](#)  
**To:** Gordon Aamoth, nosde2@aol.com  
**CC:** Jean Sazevich  
**Date:** Friday, August 01, 2008 12:10:04 PM  
**Subject:** FW: Binger

Here is correspondence relating to what will ultimately be a \$240,000 reduction in the amount to be received by Robina.

Jim left \$500,000 to Robert Pennell in his will. Because of the age difference between the two, this gift gives rise to a generation skipping tax. Apparently a tax was not paid on this bequest at the time of the initial filing, the IRS picked it up and it will be paid. Peggy says there is no way to contest it.

I will send you by separate e-mail the actual deficiency letter. Schedule R deals with this issue and shows a \$162,162 adjustment in the tax. Peggy says this amount is not correct and has further adjusted it to \$240,000.

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**From:** Halfman, Peggy [<mailto:phalfman@mwe.com>]  
**Sent:** Friday, August 01, 2008 12:00 PM  
**To:** Crosby, Thomas M.  
**Cc:** Baker, David  
**Subject:** RE: Binger

Yes, the GST tax will be born by the residue of Mr. Binger's estate, and therefore, Robina. The tax was generated by Mr. Binger's bequest, under his revocable trust, of an annuity to Robert Pennell.

Peggy A. Halfman  
McDermott Will & Emery LLP  
227 W. Monroe Street  
Chicago, IL 60606

Telephone: 312.984.3363  
Fax: 312.984.7700

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**From:** Crosby, Thomas M. [<mailto:TCrosby@faegre.com>]  
**Sent:** Friday, August 01, 2008 11:57 AM  
**To:** Halfman, Peggy  
**Subject:** RE: Binger

The distinction I am trying to make is the difference between the Marital Trust's responsibility for taxes (ie the family side) as distinguished from the estate/Robina side (Morgan).

I was not aware that a GST tax was part of the mix and am curious which transaction gives rise to the tax. As I understand the IRS deficiency letter, this tax payment was not included in the initial filing and is an additional tax payable - albeit not contested.

Given your most recent e-mail, it appears that, to the extent the tax is payable, it will reduce the residual to Robina.

---

**From:** Halfman, Peggy [<mailto:phalfman@mwe.com>]  
**Sent:** Wednesday, July 30, 2008 6:20 PM  
**To:** Crosby, Thomas M.

**Cc:** Baker, David  
**Subject:** RE: Binger

Tom,

The increase in the Tartan I LP value on Schedule G does not affect the estate tax because of the charitable residue to Robina. The IRS adjusted the value on both Schedules for consistency.

The GST tax does relate to the Pennell annuity. Robert was more than 37.5 years younger than Mr. Binger. This is not a contested item. The Estate/Trust owes the tax, which decreases the residue to Robina. I do not understand the distinction you are making between the estate and the trust in your message below, but would be happy to discuss it. I am in the office all day tomorrow.

Peggy

Peggy A. Halfman  
McDermott Will & Emery LLP  
227 W. Monroe Street  
Chicago, IL 60606

Telephone: 312.984.3363  
Fax: 312.984.7700

---

**From:** Crosby, Thomas M. [mailto:TCrosby@faegre.com]  
**Sent:** Wednesday, July 30, 2008 5:11 PM  
**To:** Halfman, Peggy  
**Subject:** RE: Binger

Thanks.

Two questions:

-Schedule G adds \$4 million + because of Tartan I LP. This item was also adjusted in the Marital Trust (Schedule F). Does the schedule G addition make a difference in the tax because the residual is going to Robina?

-Schedule R assesses a Generation Skipping Transfer Tax which is a new item to me. Does this relate to the Pennell annuity which is in the \$500,000 amount noted? I assume this tax, if it holds, would be paid by the estate and not by the trust.

---

**From:** Halfman, Peggy [mailto:phalfman@mwe.com]  
**Sent:** Wednesday, July 30, 2008 1:22 PM  
**To:** Crosby, Thomas M.  
**Subject:** Binger

Tom,

The deficiency notice is attached.

Peggy

Peggy A. Halfman  
McDermott Will & Emery, Chicago  
ph: 312-984-3363

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**From:** Crosby, Thomas M. [Add to Address Book](#)  
**To:** Halfman, Peggy  
**CC:** Gordon Aamoth, nosde2@aol.com  
**Date:** Thursday, July 10, 2008 8:55:29 AM  
**Subject:** RE: Binger Audit and Claims for Refund

Thanks - that settlement makes sense to me and takes one item off the table.

---

**From:** Halfman, Peggy [<mailto:phalfman@mwe.com>]  
**Sent:** Wednesday, July 09, 2008 3:14 PM  
**To:** Crosby, Thomas M.  
**Cc:** Baker, David  
**Subject:** RE: Binger Audit and Claims for Refund

Tom,

I am writing to update you regarding the Sherry Netherland negotiation. As we discussed, we made the counteroffer described below regarding the Sherry Netherland valuation to the IRS. The IRS said that it was not prepared to offer a counter to our counter and would write up the deficiency at the appraisal price without any discount (\$4,000,000 for each half). Given this, we discussed with counsel for the Limited Marital Trust our preference for accepting the IRS's original offer (\$3,015,000 for each half). They agreed. We conveyed our acceptance of the IRS's original offer to the IRS today. This acceptance will not be reflected in the deficiency notice as the notice was already in final form. The IRS agent will convey to IRS personnel at the next level that we are agreed on the Sherry Netherland.

Please call Dave or me if you have any questions.

Peggy

Peggy A. Halfman  
McDermott Will & Emery LLP  
227 W. Monroe Street  
Chicago, IL 60606

Telephone: 312.984.3363  
Fax: 312.984.7700

---

**From:** Crosby, Thomas M. [<mailto:TCrosby@faegre.com>]  
**Sent:** Tuesday, July 01, 2008 12:04 PM  
**To:** Halfman, Peggy  
**Subject:** RE: Binger Audit and Claims for Refund

Thanks for the summary which, subject to my additions, is accurate.

Two comments:

-I asked David whether the pursuit of the refund would be hampered by not raising the appraisal issues. He indicated that he thought that it would not be.

-I noted that, while Robina is glad to give its opinion on these issues, the final decision is to be made by the administrator of the estate.



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**From:** Crosby, Thomas M. [Add to Address Book](#)  
**To:** Gordon Aamoth, nosde2@aol.com  
**CC:** Jean Sazevich  
**Date:** Tuesday, July 01, 2008 12:04:56 PM  
**Subject:** FW: Binger Audit and Claims for Refund

The attached is self explanatory.

Peggy's outline is very similar to the one I provided to the Board after our discussion.

---

**From:** Crosby, Thomas M.  
**Sent:** Tuesday, July 01, 2008 12:04 PM  
**To:** 'Halfman, Peggy'  
**Subject:** RE: Binger Audit and Claims for Refund

Thanks for the summary which, subject to my additions, is accurate.

Two comments:

-I asked David whether the pursuit of the refund would be hampered by not raising the appraisal issues. He indicated that he thought that it would not be.

-I noted that, while Robina is glad to give its opinion on these issues, the final decision is to be made by the administrator of the estate.

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**From:** Halfman, Peggy [<mailto:phalfman@mwe.com>]  
**Sent:** Monday, June 30, 2008 12:19 PM  
**To:** Crosby, Thomas M.  
**Cc:** Baker, David  
**Subject:** Binger Audit and Claims for Refund

Tom,

I am following up on our conversation on Thursday to recap the decisions we made regarding the audit and the claims for refund.

First, we agreed that JP Morgan will not seek to re-value the Butler and Orpheum gifts to Jane Mauer in 2003 and 2004 in an effort to obtain a lower value and a greater refund of gift and estate tax to the Estate, and therefore, Robina. We concluded that the original appraisals were professionally done, that any reduction in value was not likely to be substantial, that the expense of obtaining new appraisals was not warranted, that introduction of the valuation issue into the claim for refund process made it more likely that the IRS would seek to assert higher valuations as an offset to our claims for refund based upon the Mauer settlement, and that any strategic benefit generated by raising the valuation issue did not justify the expense and risks associated with pursuing it. You also informed us that Jane Mauer recently sold the Orpheum property for significantly more than the gift tax value.

Second, we discussed the IRS's settlement offer on the estate tax valuation of Mr. Binger's and the Limited Marital Trust's 50% interests in the Sherry Netherland Coop. On Mr. Binger's federal estate tax return, as filed, each 50% interest in the Sherry was valued at \$2,240,000, which represented a 44% discount off the appraisal price of \$4 million. The IRS has offered the Estate a value of \$3,015,000 for each 50% interest in compromise, which represents a 10% discount off of the actual sales proceeds for the Sherry of \$3,350,000. The Limited Marital Trust has proposed that instead of accepting the IRS's offer, the Estate and Limited Marital Trust make a counteroffer to the IRS of \$2,613,000, which represents a 22% discount from the actual sales proceeds. In our call on Thursday, we agreed that this counteroffer is a reasonable approach, even though the IRS may reject the Estate's counter-offer of \$2,613,000 and may not renew its original settlement offer of \$3,015,000.

Please let me know if my summary of our conclusions is inaccurate in any way. We will proceed with the counteroffer to the IRS early this week.

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From: Crosby, Thomas M. [Add to Address Book](#)  
To: Gordon Aamoth, nosde2@aol.com, Schroeder@medicine.UCSF.edu, pkaroff@TPI.org  
CC: Jean Sazevich  
Date: Thursday, June 26, 2008 4:10:41 PM  
Subject: IRS Report III

Tuesday I was contacted by Peggy Halfman about a conference call today with David Baker (both of McDermott, Will) to give me a report on the recent meeting with the IRS (See my IRS Report II).

The discussion took place this AM:

1. I indicated that I had discussed the meeting with Bill Brody and was generally familiar with the open issues related to both the family and the foundation.
2. The purpose of their call was to determine (i) whether Robina wanted to take the same position as the family on the discount for the New York apartment and (ii) whether Robina desired to contest the Butler property appraisal filed by Jim Binger as a part of his 2004 gift tax return as being too high.
3. On the New York apartment, the estate took a 44% discount from the appraised value on the theory that small partnership interests were held by different entities therefore neither the estate nor the marital trust had control nor was there any liquidity. The value of the apartment was been agreed to as the sale price but the question of the discount remains. The IRS has offered a 10% discount. The family wants to counter with a 22% discount with the hope of settling in the middle. Baker said that (i) it is possible but difficult for the marital trust and the estate (Robina) to take a different position on this issue, (ii) whatever position was taken by the estate would have no effect on the refund issue and (iii) the main risk was that the IRS would withdraw its 10% offer.

I indicated that the estate would be comfortable going with the family on the 22% position. They are comfortable in doing so.

4. Baker and Halfway have mentioned on several occasions that we/they should consider contesting the 2004 gift tax appraisal of the Butler property as a tactic in the refund argument. Today they mentioned that this concept comes, in part, from a comment by the Oppenheimer firm who represented the Foundation during the Jane period that the appraisal might be high. Baker had no foundation for their statement. He said he was familiar with the appraisal. The appraised value was approximately \$39,000,000 divided primarily between the building (\$27,000,000) and the adjacent parking lot (\$12,000,000). I have reviewed the appraisal and find it to be a reasonable, professional job done by a qualified Minneapolis appraiser in good standing. The appraisals run over 100 pages each; deal with the market value, income and comparable sale approach and seem quite reasonable to me. Relevant is the fact that in the 2004 gift tax return was the final gift of the so called Orpheum Lot where an aggregate appraised gift tax value of approximately \$4,000,000 was used. That property has been sold by Jane for over \$10,000,000 during the last 12 months. I questioned whether Baker thought that not contesting the appraisal would put the estate at a substantial disadvantage in the refund argument. He said it would not. He admitted that such a contest would require another appraisal by August 3rd, would be time consuming and otherwise expensive. He indicated that it was unlikely the IRS would question the appraisal in their formal August letter of deficiency but, importantly, if we raised the issue, they could question the appraisal as being too low in arguments related to the refund. Further, and more importantly, they could also question the appraisal of the Orpheum lot as being too low in the refund argument. I said that, while the decision to contest the appraisal was theirs as representatives of the administrators of the estate, Robina would not contest it if left to their decision because (i) time and expense, (ii) any adjustment in appraised value would likely be slight given the quality of the work already done and (iii) little was to be gained by bringing all of the appraisals into question. [I had previously discussed the conclusion of the preceding sentence with Aamoth and Spencer.] Accordingly, the gift tax appraisal will not be appealed.

5. The IRS letter of deficiency will be sent in early August of this year - three years after the date of the filing of the estate tax return which filing date was nine months after Jim's death. Baker believes that none of the open issues will be settled which means that a deficiency will be stated, ie an additional tax bill will be sent, for the blockage discount taken by the marital trust on 3M stock, the partnership discount taken by the marital trust for the Tartan partnership, for issues related to the apartment in New York and for the deduction of certain Dorsey legal fees by the estate. Further, the refund will be denied.

6. After the letter of deficiency is received, several courses of action are available to Robina - which I will not detail here as they are lengthy and I am not sure fully understood by me. Baker would like to get into federal district court on the refund issue because of the quality of the judges and because a jury trial is available. Baker does plan to file a refund claim for the 2004 gift tax return reflecting Jane's settlement which is independent of the estate tax matters - although if no gift tax refund is given, there would not be a claim for a refund of the estate tax related to it.

7. Precise timing is uncertain - but lengthy - particularly if the gift tax refund must run its independent course before the estate tax issues can be settled. Baker's hope is that government representatives - other than those currently on the matter who he sees as not willing to negotiate at all - will appear at some stage and that meaningful settlement discussions might occur.

8. I indicated to Halfway and Baker was that my hope was that the letter of deficiency would at least establish the parameters of Robina's risks. If, as we hope, a small refund might be owed on the New York apartment and on the Dorsey legal fee, the downside could be defined and Morgan could free up the remainder. It is clear that the upside, ie the refund, will be up in the air.

We need to revisit this issue once the letter of deficiency is issued which should be before the August Board meeting. We might want to schedule a conference call for the entire Board with Tyson, Halfway and Baker to discuss these issues.

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From: Crosby, Thomas M. [Add to Address Book](#)  
To: nosde2@aol.com, Gordon Aamoth  
CC: Jean Sazevich  
Date: Friday, June 20, 2008 11:13:04 AM  
Subject: Baker Bldg Appraisal

The IRS has, apparently, agreed to accept the appraisal of the Butler property filed with Jim's 2004 gift tax return and included in the estate tax return. Because of the probability that the IRS and the estate will not be able to agree on certain items, the IRS will probably send out a notice of deficiency in August. It is probable that the valuation of the Baker property will not be noted in the deficiency.

Anita Tyson and the McDermott lawyers have suggested that, mostly as a bargaining chip in the refund dispute, the estate contest the valuation as being too high - even though it was Jim Binger who obtained and filed the valuation as a part of his 2004 gift tax return. We know that Jim was not in charge but the IRS will assume he was.

All concede that such a valuation contest would take time and money. The money would relate to the need to obtain new appraisals to "correct" the one filed as well as the legal and administrative time to process the matter and to negotiate with the IRS.

We have told Anita that we are inclined not to contest the valuation because of the time and money but did so without having reviewed the appraisal.

I have now done so and have the following comments:

1. The appraised value of the gift, 100% interest in Butler Properties, LLC, was \$39,576,225 and had three components:

-The Butler Building at \$27,345,997 which included \$26,000,000 for the building and \$1,345,997 for other assets, i.e. cash in the bank, etc.

-The vacant property used as a parking lot at 501 First Ave. North which was valued at \$12,000,000, and

-a 5% interest in the new Graves hotel on Hennepin Avenue which was valued at \$155,000

2. The Butler building in 2003 had a cash flow from operations of \$3.8 million and a cash flow of \$2.957 million after certain other expenses including capital improvements, leasing costs and the like. The three elements of value (replacement, market comparison and capitalized income) were all quite close to the \$26,000,000 number. A capitalization rate of 10 was used which is not particularly aggressive. The Hennepin County Assessor's most recent valuation prior to the gift (as of 1/1/2003) was \$23,500,300. The building contains 412,013 square feet, was 80% occupied and was in good condition.

3. The parking lot had a cash flow from operations in 2003 of \$1,101,182 which had been as high as \$1,364,474 in 2001. Because there are no buildings, there is no depreciation and very few expenses of a capital nature. The capitalization rate for this property was 7.50% which appears to be reasonable under the circumstances. The 2003 county assessor's valuation was \$4,409,500.

4. I will not comment on the interest in the Graves hotel because of the relatively small dollar amount.

5. Both appraisals are very professionally done by a respected Minneapolis appraiser. Each is over 100 pages long. Even if a new one were obtained, I doubt whether the new value would be materially different - up or down - from the Binger one.

6. Although interests in an LLC are being conveyed, no discount is taken for the fact that it is an LLC. The

reason for this position is probably that 100% of the interests were being transferred.

As a result of the foregoing, were I making the decision on behalf of Robina, I would not contest the appraisal because it appears to be well done and reasonable in its conclusion. The first step would be to contact another appraiser, ask him/her to review the existing one and seek an opinion as to whether a lower amount is possible.

Whose decision is it whether or not to contest the appraisal? The administrator of the estate, i.e. Morgan, has that responsibility. While I think it appropriate to voice an opinion on the subject, it should only be an opinion and Morgan should understand that it is making the decision. I would not want Robina to take a position on a matter in the estate administration where it could be blamed for an outcome, i.e. the inability to contest the Butler valuation meant that we had nothing to offer in the refund issue upon which a less than favorable result was obtained.

I am also not sure about the logic of contesting the appraisal in that it was submitted by Jim Binger, all decisions with respect to it were made by him and it was accepted by his accountant in filing the return. All of those actions were, arguably, under the supervision of McDermott (Morgan?) as the lawyers orchestrating the gift. Further, if the value is contested, the IRS may well take the position that the one filed was too low. Having reviewed the appraisal, I can see how one could argue that it is too low.

I believe that Robina should communicate to Anita that (i) we have reviewed the appraisal and find it reasonable, (ii) were we making the decision, we would not contest the valuation and (iii) we are concerned about the time, administrative and legal expense and the possibility of the IRS seeking a higher valuation. We should be very careful to point out that the final decision is hers in that Morgan needs to do whatever is necessary to prevail on the refund claim.

PS: The gift tax returns are interesting. Jim was busy in making gifts to Jane in 2004, the year of his death:

- 7/01/04 \$570,960 for the remainder of the non management portion of the Orpheum lot
- 8/02/04 \$42,929 for the management portion of the Orpheum lot
- 9/16/04 \$8,355,800 for all of Tartan Farms Corp which was his management company
- 9/23/04 \$39,576,225 for the Butler gift discussed above
- 10/13/04 \$700,000 for all of Tartan Stables.

In addition, in 2003 he gave her 80% of the non management portions of the Orpheum lot for \$2,404,000. The Orpheum property was sold by her in late 2007 or early this year for over \$10,000,000 where the aggregate value of the gifts (all accepted by the IRS) was \$3,017,889.



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From: Crosby, Thomas M. [Add to Address Book](#)  
To: Gordon Aamoth, nosde2@aol.com, Schroeder@medicine.UCSF.edu, pkaroff@TPI.org  
CC: Jean Sazevich  
Date: Thursday, June 19, 2008 12:34:49 PM  
Subject: IRS - Report II

I spoke with Bill Brody, the attorney for the Mac Binger side of the family, yesterday on the status of the IRS matters. As you will remember, August 3, 2008 is the day a settlement needs to be reached or the IRS will send a deficiency notice, ie a notice that more taxes are due.

Conclusion: a settlement is highly unlikely which means that a deficiency notice will be sent and the matter will go to the appellate division.

Apparently there was a meeting last week in Minnesota with the IRS. Brody and Bill Berens, attorney for the other side of the Binger family, were in attendance and the McDermott, Will attorneys participated by telephone. I do not think Robina was advised of the meeting nor has it had a report.

Brody's summary:

1. There is no movement on the blockage discount for the 3M. The estate is now trying to get a discount on only that portion which was needed to pay taxes. The IRS takes the position that, because the market went up during the sales period (due to market action), no discount is warranted.
2. On the Tartan partnership discount where the Estate took, I believe, a 40% discount, there is a recent tax court case (Holman) involving similar partnership language and the same discount appraiser used in the Binger estate in which a 12.5% discount was determined. That decision has the Binger estate appraiser looking for ways to distinguish the decision and has emboldened the IRS at its position of 10%.
3. On the Sherry apartment in New York City, the IRS is willing to grant a 10% discount from the sale amount - which I think will be acceptable to the family.
4. The IRS has not moved on the refund matter. Not only does the IRS take the position that the estate is not entitled to a refund but also it says that Jane is not entitled to take a charitable deduction reflecting the money's going to Robina.

If the deficiency notice is issued, further discussions will be with a new IRS team in the appellate division which will clearly take more time and may not have a different tune.

In general, not a very encouraging report.



# **FUTURE BOARD MEETING DATES** **2008-2009**

| DATE                                                              | TIME/PLACE                          |
|-------------------------------------------------------------------|-------------------------------------|
| November 19, 2008 (Wednesday)<br>Conference Call                  | 9:00 a.m. to 11 a.m. (Central Time) |
| February 16-17, 2009 (Monday and Tuesday)<br>Winter Board Meeting |                                     |
| May 11 <u>or</u> 18                                               | 9-11 telephone                      |
| Nov 16                                                            | 9-11 telephone                      |
| August 24, 25, 26                                                 |                                     |
|                                                                   |                                     |

# 2009

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| <p>January 2009</p> <p>S M T W T F S</p> <p>1 2 3</p> <p>4 5 6 7 8 9 10</p> <p>11 12 13 14 15 16 17</p> <p>18 19 20 21 22 23 24</p> <p>25 26 27 28 29 30 31</p> | <p>February 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5 6 7</p> <p>8 9 10 11 12 13 14</p> <p>15 16 17 18 19 20 21</p> <p>22 23 24 25 26 27 28</p>                      | <p>March 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5 6 7</p> <p>8 9 10 11 12 13 14</p> <p>15 16 17 18 19 20 21</p> <p>22 23 24 25 26 27 28</p> <p>29 30 31</p>    |
| <p>April 2009</p> <p>S M T W T F S</p> <p>1 2 3 4</p> <p>5 6 7 8 9 10 11</p> <p>12 13 14 15 16 17 18</p> <p>19 20 21 22 23 24 25</p> <p>26 27 28 29 30</p>      | <p>May 2009</p> <p>S M T W T F S</p> <p>1 2</p> <p>3 4 5 6 7 8 9</p> <p>10 11 12 13 14 15 16</p> <p>17 18 19 20 21 22 23</p> <p>24 25 26 27 28 29 30</p> <p>31</p>    | <p>June 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5 6</p> <p>7 8 9 10 11 12 13</p> <p>14 15 16 17 18 19 20</p> <p>21 22 23 24 25 26 27</p> <p>28 29 30</p>        |
| <p>July 2009</p> <p>S M T W T F S</p> <p>1 2 3 4</p> <p>5 6 7 8 9 10 11</p> <p>12 13 14 15 16 17 18</p> <p>19 20 21 22 23 24 25</p> <p>26 27 28 29 30 31</p>    | <p>August 2009</p> <p>S M T W T F S</p> <p>1</p> <p>2 3 4 5 6 7 8</p> <p>9 10 11 12 13 14 15</p> <p>16 17 18 19 20 21 22</p> <p>23 24 25 26 27 28 29</p> <p>30 31</p> | <p>September 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5</p> <p>6 7 8 9 10 11 12</p> <p>13 14 15 16 17 18 19</p> <p>20 21 22 23 24 25 26</p> <p>27 28 29 30</p>   |
| <p>October 2009</p> <p>S M T W T F S</p> <p>1 2 3</p> <p>4 5 6 7 8 9 10</p> <p>11 12 13 14 15 16 17</p> <p>18 19 20 21 22 23 24</p> <p>25 26 27 28 29 30 31</p> | <p>November 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5 6 7</p> <p>8 9 10 11 12 13 14</p> <p>15 16 17 18 19 20 21</p> <p>22 23 24 25 26 27 28</p> <p>29 30</p>         | <p>December 2009</p> <p>S M T W T F S</p> <p>1 2 3 4 5</p> <p>6 7 8 9 10 11 12</p> <p>13 14 15 16 17 18 19</p> <p>20 21 22 23 24 25 26</p> <p>27 28 29 30 31</p> |





# UNIVERSITY OF MINNESOTA

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The Law School  
Walter F. Mondale Hall*

*Room 381  
229-19th Avenue South  
Minneapolis, MN 55455  
Office: 612-625-4841  
Fax: 612-625-2019*

June 20, 2008

Dr. Gordon Aamoth  
President, Robina Foundation  
4900 IDS Center  
80 South 8<sup>th</sup> St., Ste. 550  
Minneapolis, MN 55402

Dear Gordon:

Enclosed please find a revised University of Minnesota - Law School proposal to the Robina Foundation. We have modified our prior proposal to build more explicitly on the Law School's existing areas of strength. We believe the new proposal will lead to the kind of transformative change that James Binger envisioned.

We greatly appreciate the assistance the Robina Foundation has already provided to the Law School, and I look forward to discussing the revised proposal with you and other members of the Board at the August meeting.

Best regards,

*David Wippman (nk)*

David Wippman  
*Incoming Dean  
University of Minnesota - Law School*

DW/vn



## Gordon Aamoth

---

**From:** Schroeder, Steve [schroeder@medicine.ucsf.edu]  
**Sent:** Friday, July 25, 2008 10:51 AM  
**To:** JEAN SAZEVICH; Gordon Aamoth  
**Subject:** ANW grant proposal

Hi Jean and Gordon,

I have read the revised proposal, and have the following comments:

- \* It is much clearer and easier to read than the first version.
- \* It is still going to be a tough project to pull off.
- \* The staff have added a lot of emphasis on using the chronic disease model to bolster primary care. I suspect this reflects the influence of Tom Bodenheimer.
- \* There are major changes from Phase I to Phase II, which may limit generalizability of the pilot phase. Phase I is in the resident clinic with a large number of immigrants, whereas the RCT is in suburban clinics with practicing MDs and few immigrants.
- \* They are using non clinically trained guides, a departure from the Wagner model. This is done for valid economic reasons. But the skills required for the pilot phase population may be quite different from the RCT population (Phase II).
- \* Especially for the pilot phase, I worry about patient leakage is what is likely a highly transient population. I did not see mention of this in the proposal.
- \* Might want to put some \$ for Tom Bodenheimer as an implementation consultant in year one.
- \* In the budget, not clear why the pilot extends into year 3.
- \* I would recommend paying year by year, as the budget is likely to change.
- \* Ready to discuss at the August meeting. Will the other members get this proposal?

Steve

Steven A. Schroeder, MD  
Distinguished Professor of Health and Health Care, Department of Medicine  
Director, Smoking Cessation Leadership Center  
University of California, San Francisco  
Phone: (415) 502-1881  
Fax: (415) 502-5739  
Web site: <http://smokingcessationleadership.ucsf.edu>  
**Refer a smoker to 1-800 QUIT NOW.**

800 E. 28th Street  
Minneapolis, MN 55407  
612-863-4000  
www.allina.com

July 18, 2008

Gordon M. Aamoth, MD  
President and CEO  
Robina Foundation  
4900 IDS Center  
80 South 8<sup>th</sup> Street  
Minneapolis, MN



Dear Dr. Aamoth:

On behalf of Abbott Northwestern Hospital and the Abbott Northwestern Foundation and most importantly the patients and families that we will serve through and by the innovative approach proposed in our request, it is my privilege to submit to the Robina Foundation Board of Directors the enclosed proposal.

Our proposal, in response to Mr. Binger's vision to transform health care, addresses the looming chronic disease crisis and the troubling state of primary care. The overarching aim of our intended intervention is to use a team-based, patient-centered approach that focuses intensely on the basics of chronic disease management and supports the patient's ability to be their own agent in achieving optimal health. This proposal is unique in that it will demonstrate an economically viable medical home model with active patient/family participation. Additionally, it harnesses the power of the electronic health records, with care contracts and care guides that continuously support patients' health. With demonstrated success, this model can be readily scalable to improve the lives of many while be cognizant of using resources wisely.

Collectively, the proposal, budget and budget justification capture our plans and clearly state how we propose to use the Foundation's resources. Therefore, we respectfully request a grant in the amount of \$5,995,070 over three years.

We look forward to the Robina Foundation site visit scheduled for August 27, 2008 at the Robina office at 8 a.m. Dick Adair MD, the intervention's Principal Investigator, will lead our presentation team.

Thanks again to you and all the Robina Directors for your continued support, encouragement and guidance as we have moved this historic opportunity forward these past few years. Together, we can honor Mr. Binger by bridging the present with the future and fundamentally improve the current health care system.

Sincerely,

Penny Wheeler, M.D.  
Chief Clinical Officer  
Allina Hospitals & Clinics

Cc: Dick Adair, M.D., Principal Investigator  
Chris Morrison, Chair, Abbott Northwestern Foundation Board  
Rich Meyer, President Abbott Northwestern Foundation

800 E. 28th Street  
Minneapolis, MN 55407  
612-863-4000  
www.allina.com

July 18, 2008

Gordon M. Aamoth, MD  
President and CEO  
Robina Foundation  
4900 IDS Center  
80 South 8<sup>th</sup> Street  
Minneapolis, MN

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Our proposal, in response to Mr. Binger's vision to transform health care, addresses the looming chronic disease crisis and the troubling state of primary care. The overarching aim of our intended intervention is to use a team-based, patient-centered approach that focuses intensely on the basics of chronic disease management and supports the patient's ability to be their own agent in achieving optimal health. This proposal is unique in that it will demonstrate an economically viable medical home model with active patient/family participation. Additionally, it harnesses the power of the electronic health records, with care contracts and care guides that continuously support patients' health. With demonstrated success, this model can be readily scalable to improve the lives of many while be cognizant of using resources wisely.

Collectively, the proposal, budget and budget justification capture our plans and clearly state how we propose to use the Foundation's resources. Therefore, we respectfully request a grant in the amount of \$5,995,070 over three years.

We look forward to the Robina Foundation site visit scheduled for August 27, 2008 at the Robina office at 8 a.m. Dick Adair MD, the intervention's Principal Investigator, will lead our presentation team.

Thanks again to you and all the Robina Directors for your continued support, encouragement and guidance as we have moved this historic opportunity forward these past few years. Together, we can honor Mr. Binger by bridging the present with the future and fundamentally improve the current health care system.

Sincerely,

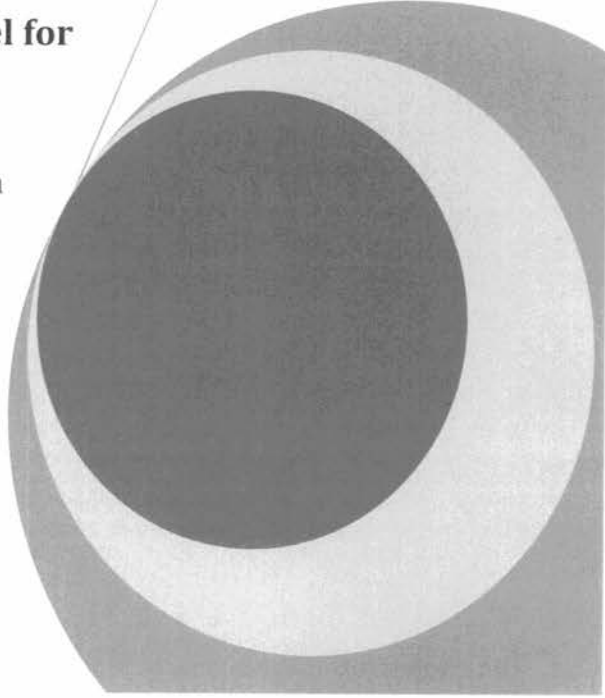
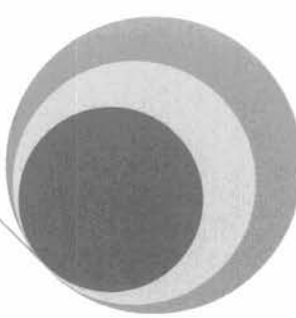
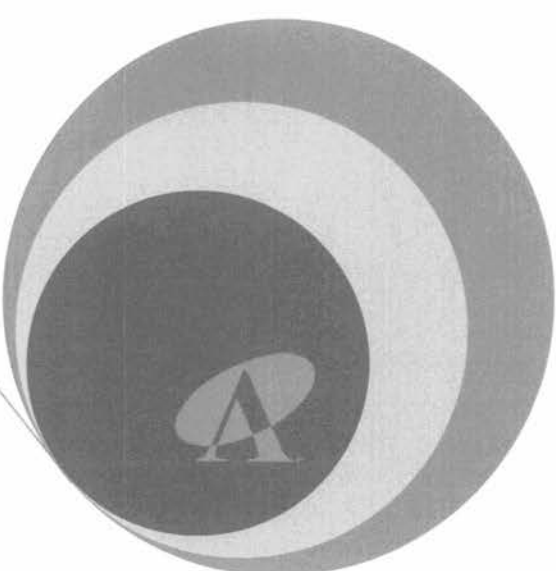


Penny Wheeler, M.D.  
Chief Clinical Officer  
Allina Hospitals & Clinics

Cc: Dick Adair, M.D., Principal Investigator  
Chris Morrison, Chair, Abbott Northwestern Foundation Board  
Rich Meyer, President Abbott Northwestern Foundation

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## **Care Guides in the Primary Care Office:**

**Developing and testing an efficient, sustainable model for  
improving chronic disease outcomes**

**A proposal for innovation submitted to the Robina Foundation  
by Abbott Northwestern Hospital**

**Richard Adair, MD**  
Principal Investigator

**Penny Wheeler, MD**  
Executive Sponsor

July 2008

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## Executive Summary

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In response to the looming chronic disease crisis and the troubling deterioration of primary care in this country, we propose a test of a sustainable, primary care-based intervention to increase physician and patient adherence to national guidelines for diabetes, heart failure, and hypertension care. These diseases were chosen for study because care guidelines are widely accepted and correlate well with clinical outcomes such as death, myocardial infarction, stroke, and kidney failure. The theoretical framework for the intervention is Wagner's well-described chronic care model. The innovative approach is grounded in Bodenheimer's teamlet model for care and comprises three key components: non-clinically trained care guides, an electronic care contract, and team-oriented care. Care guides based in primary care clinics will interact with patients regularly, providing informational and navigational support and encouraging self-care. Patients and primary care providers will sign a contract attesting to their collective commitment to achieve clearly articulated clinical benchmarks for optimal care, and this contract will be embedded within each patient's electronic medical record. The electronic care contract and summary of targeted treatment goals will be visible to providers in both inpatient and outpatient settings linked by the system, serving as a platform for inter-provider communication and coordinated care.

The model will be pilot-tested among 500 diabetes, heart failure, and hypertension patients in a single, inner-city primary care clinic affiliated with Abbott Northwestern Hospital. Adherence to care guidelines will be measured before and after introduction of the care model, providing a clear, quantitative measure of success or failure. During the one-year pilot study, the intervention strategy and methods will be evaluated and refined. The second phase of the program will be a full-scale implementation of a randomized controlled trial in three additional primary care clinics in the Abbott Northwestern service area, assessing efficacy in approximately 5,000 chronic disease patients supported by two dozen care guides. Intervention arms will be designed to elucidate aspects pertinent for wide dissemination of the model, including identification of the optimal guide-patient ratio, clarification of the educational, personal attribute, salary, and training requirements of care guides, characterization of the patients most likely to benefit from the intervention, and description of the care guide services that are most helpful.

The overarching aim of this intervention is to use a team-based, patient-centered approach to focus intensely on the basics of chronic disease management and empower patients to self-care. The nuclear care team formed within the patient's primary care practice – patient, physician, care guide, and family/friend – will provide a centralized human core that promotes accountability, focus, responsiveness, and support from all members of the care team. This ultimately should produce care that is truly patient-centered and a fully realized "medical home".

## Introduction

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The deterioration of primary care in the United States is a resonant theme in current health services literature and the state of disrepair is approaching crisis levels<sup>1,2</sup>. The number of primary care physicians is dwindling as ambulatory settings continue to be characterized by excessive demands on physicians and poor system support<sup>1,3</sup>. High patient volumes continue to challenge the translation of potential care opportunities into effectively delivered best practice care, and the current fee-for-service reimbursement structure inherently devalues time-intensive, non-procedural efforts aimed at communicating best practice guidelines. The health and safety of patients is often compromised in the current setting and particularly vulnerable are the estimated 125 million Americans with chronic diseases who depend upon primary care for effective therapy and management<sup>4,5</sup>. While clear care guidelines exist for major chronic conditions such as hypertension, diabetes, and heart failure, the proportion of adults achieving optimal care benchmarks is dishearteningly low. A fundamental failing of the primary care system is the persistent gap between the evidenced-based knowledge that is encompassed in current disease management guidelines and the ability to apply them effectively in practice. A significant proportion of American adults continue to maintain levels of risk factors that place them at high risk of adverse clinical events, and much is being lost, in terms of cost and quality of life, due to preventable acute care experiences. Primary care in the U.S. needs to be reinvented so that care in accordance with established guidelines is provided to all patients effectively and systematically, and medical residents once again begin to view primary care as an attractive career option.

Innovators in the field of primary care redesign have focused efforts on two fundamental barriers to delivery of high-quality care: (1) time constraints that render primary care physicians incapable of executing all recommended care guidelines during the typical 15 minute patient-physician encounter, and (2) labor intensive care coordination activities that are neither system supported nor reimbursable. A leading authority advises, "A more thoughtful solution to physicians' time constraints requires a combination of **team care and electronic encounters**."<sup>2</sup>. The project proposed herein aims to build on advice and lessons learned by the pioneering minds in primary care redesign by investigating: (1) how electronic medical records can be used to construct a system-supported platform for chronic disease management and care coordination in the ambulatory environment, and (2) how affordable, personnel, as part of a coordinated care team, can bolster the efforts of physicians by facilitating treatment adherence and coordination, and providing practical support to patients encountering logistical and emotional barriers to care. The ultimate goal of this work is improve the measurable clinical outcomes of patients. We also aim to provide the broad community of primary care physicians with a realistic strategy and a suite of well-developed tools that will enable them to implement effective care model redesign in their clinics.

## 1. Specific Aims

The specific aim of this proposal is to increase physician and patient adherence to established clinical care guidelines for diabetes mellitus (DM), hypertension (HTN), and heart failure (HF). The proposed intervention comprises three key components, which, when integrated as part of a broader system, can improve the quality of care provided to patients by primary care physicians— (1) a coordinated **care team**, (2) a **care contract**, and (3) a **care guide**.

**Care Team** – As part of the current intervention, a coordinated care team will be identified for each patient. The nuclear care team will consist of the patient, a care guide, the primary care physician (PCP), and a key family member or friend named by the patient who agrees to support the patient in efforts to achieve clinical benchmarks. In addition, an extended care team, which could include hospitalists, pharmacists, diabetes educators, specialists, and complementary medicine providers, will be involved as needed. A primary goal will be to alleviate the inadequacies of traditional, ad hoc care teams by using regular electronic and phone communication, facilitated by the care guide, to ensure that efforts are focused collectively on meeting best practice guidelines for the patient.

**Care Contract** – A primary tool in the intervention will be an electronic care contract residing within the patient’s electronic medical record and given to the patient in a printable, portable format. The purpose of this document will be two-fold: (1) to provide an electronically integrated tool to support patients and care teams in aligning and monitoring efforts to achieve specific benchmarks of appropriate, guideline-based chronic disease management, and (2) to provide a formal testimonial of the patient’s commitment to his or her own care, and provide regular, positive reinforcement.

**Care Guide** – The central facilitator of the proposed intervention will be the care guide. As defined in this intervention, the care guide will be an individual without formal medical training whose general functions will include:

- encouraging patients to take control of their chronic illness
- educating patients about the considerable benefits of best practice treatment
- communicating with patients, families and providers to keep the entire care team, including the PCP, focused on meeting care guidelines
- engaging family/friend support in a formal and consistent manner
- supporting medication and treatment adherence
- identifying and facilitating resolution of barriers to quality care
- facilitating referrals to extended care team members
- introducing patients to the wide variety of services available within Allina, including counseling on mental illness, chemical dependency, diet, smoking cessation, and diabetes
- connecting appropriate patients with resources offered at Abbott Northwestern’s Institute for Health and Healing (IHH), which include patient education courses that promote self-managed health and wellness and integrative approaches to managing stress and anxiety

### 1.1 Description of the Intervention Sites

Abbott Northwestern Hospital (ANW) is part of Minneapolis-based Allina Hospitals & Clinics, an integrated healthcare system that includes hospitals, clinics and other health services, and provides care throughout Minnesota. Allina serves approximately 1.5 million Minnesotans, which represents 30% of

the Minnesota market. ANW is the largest private hospital in the Twin Cities metropolitan area with 1,600 medical staff and 38,000 inpatient admissions in 2007. The ANW medical complex occupies six city blocks near downtown Minneapolis and includes the Sister Kenny Institute for physical rehabilitation, Children's Hospitals and Clinics – Minneapolis, and a state-of-the-art heart, neurology, orthopedics, and spine hospital. ANW is a premier tertiary care facility and for the past six years has been cited as one of the country's best hospitals according to U.S. News & World Report's rankings of "America's Best Hospitals". ANW has a strong tradition of medical education and research and is home to a nationally recognized residency training program.

Abbott Northwestern General Medicine Associates (ANGMA) is a group of internal medicine physicians affiliated with ANW who provide a full range of primary medical care to adult patients at two clinic sites: the ANGMA-Medicine clinic, and the ANGMA-Center for Outpatient Care (ANGMA-COC). The ANGMA-Medicine clinic is ANW's internal medicine residency continuity clinic located on the campus of ANW. It serves as a community clinic where 56 residents and faculty provide care for approximately 5,000 mostly low-income and minority patients from the inner-city. A large proportion of patients are immigrants from Africa, and there are a substantial number of patients from south and east Asia as well as Latin America. Residents have the opportunity to develop long-term patient-physician relationships as they care for the same panel of patients during their three years of training. Caring for these underserved patients is an important mission of ANW and its medical education program as well as for Allina Hospitals & Clinics as an organization. Allina provides free medical care across the system to any individual living below 275% of the federal poverty level. Residents and physician faculty at the ANGMA-Medicine clinic have previous experience using a systems approach to improve outcomes for diabetes and hypertension<sup>6,7</sup>.

In contrast to the ANGMA-Medicine clinic, the ANGMA-COC clinic, located in Minneapolis' southwest suburb of Edina, has a distinctly different patient population that is more affluent and less ethnically diverse. The ANGMA-COC clinic is housed within a large, medical facility owned by ANW designed to provide comprehensive and integrated outpatient care, including onsite specialist care, advanced imaging, laboratory and day-surgery services. The clinic is staffed currently by 13 internists who care for approximately 10,000 patients.

In addition to ANGMA, ANW also receives referrals from Allina's own system of clinics, the Allina Medical Clinic (AMC), which is a multi-specialty medical group of over 600 primary care health practitioners who serve approximately 500,000 active patients. The AMC comprises 43 clinics that serve communities in both the urban and suburban areas of Minneapolis and St. Paul. Two of these clinics, AMC-Woodlake and AMC-Edina, will participate in the second phase of the intervention.

The IHH at ANW, while not an intervention site, is a major asset because it is one of the foremost integrative medicine programs in the United States. Founded in 2003 by the George Family Foundation and the Ted & Roberta Mann Foundation, the Institute provides integrative medicine services to both inpatients at ANW and to outpatients through a hospital-based clinic. The vision of the IHH is to transform healthcare by blending the best of conventional medicine with healing therapies and education, and emphasizing care for the whole person. The Institute's educational efforts include training hospital staff in integrative therapies, holistic approaches to care, and principles of self-care promotion. This educational expertise will be utilized in the current intervention in training care guides in motivational theory and behavioral modification techniques. In addition, care guides will have the opportunity to refer clinic patients to the numerous specialized health education and self-care skills development programs offered to patient groups through the IHH Outpatient Clinic.



## 1.2 The Electronic Medical Record

Allina Hospitals & Clinics has implemented an electronic medical record (EMR) across the system called Excellian (an Epic product). Allina Hospitals & Clinics has been recognized for its industry-leading EMR system by being the 2007 recipient of the Davies Award, the preeminent award of the Healthcare Information and Management Systems Society. By November 2004, both ANGMA primary care clinics had fully implemented Excellian, including practice management and clinical components. Pertinent to the proposed intervention, Excellian includes data fields required for monitoring the management of diabetes, heart failure and hypertension, which include gender, age, systolic and diastolic blood pressure, glycosylated hemoglobin, urinary albumin, medication use, diabetes status, and smoking status. Laboratory values populate Excellian fields via integrated links with clinical laboratories. Current functionality can accommodate the integration of customized navigators, documents, and html-based links, which ensures the feasibility of the care contract component of the intervention

## 1.3 Broad Scope and Objectives

- 1) Develop care guide position description including planned activities; define required competencies and develop training modules
- 2) Formalize and integrate the care contract within the EMR
- 3) Establish program in existing clinic structure, including recruiting and training staff, and “bricks and mortar” accommodations
- 4) Consolidate and prepare referral information and resources
- 5) Convene and prepare affiliated care providers
- 6) Recruit and enroll participants and key family members; assign patient-guide teams
- 7) Implement the intervention in a single clinic site
- 8) Measure and understand process and impact
- 9) Summarize pilot learnings and refine the intervention in preparation for project expansion
- 10) Implement a large randomized controlled trial of the intervention in three additional ambulatory settings
- 11) Disseminate findings to the broader healthcare community

## 1.4 Overview of the Framework for Design

The first six months of the project will be dedicated to the preparatory work required for a pilot test of the intervention at the ANGMA-Medicine clinic. During this intense pre-work phase, all essential project staff will be hired, a training curriculum will be finalized, care guides will be trained, the care contract will be built and integrated into Excellian, clinic “brick and mortar” modifications will be made, and the project team will convene meetings with potential extended care team members to introduce the intervention and forge cooperative relationships.

Near the end of the six month pre-work phase, when the team is prepared to initiate the intervention, the EMR database will be queried for purposes of identifying a pool of patients eligible for participation. For a period of about three months thereafter, physicians and care guides at the ANGMA-Medicine clinic will recruit patients for enrollment. Patients will be invited to participate in a baseline visit at the clinic where they will meet their care guides and other staff, provide informed consent, and make a formal commitment to participate in the program and become personally vested in their care by signing a care contract. For twelve months, the patient will receive services from the care guide and

access the clinical members of the care team as needed. Clinical benchmarks will be monitored and patients will be provided with feedback on their progress each time they access care or communicate with a care guide.

About one year after the first patient is enrolled, the investigators will conduct preliminary, pre-test/post-test analyses to assess empirically the efficacy of the intervention for improving the number of clinical benchmarks achieved and maintained by patients. If preliminary results demonstrate promise, the project team will refine the intervention based on participant feedback and other process measures and prepare to initiate the intervention in three additional clinic sites: ANGMA-COC, AMC-Woodlake, and AMC-Edina. This expansion of the project will be a full-scale, 12-month randomized controlled trial (RCT) of the intervention. The sample size will be significantly larger than in the pilot allowing for multiple treatment arms and subset analyses, but the exact design of the RCT will not be defined until pilot data have been analyzed. The project team will remain flexible about the intervention arms in the larger RCT, preferring that the design be driven by pilot results and tailored to answer pertinent scientific questions that evolve during the pilot. Aims for further study likely will include identification of the optimal guide-patient ratio, clarification of the educational, personal attribute, salary, and training requirements of care guides, and specification of the patient selection process and a method for patient-specific customization of services aimed at maximizing efficiency and benefit.

## 1.5 Measured Outcomes

### PRIMARY OUTCOME:

Change in the absolute number of disease-specific clinical benchmarks attained:

#### FOR DIABETES –

- Domain of possible scores = {0,1,2,3,4,5,6,7,[8]} (8 for those with abnormal albuminuria)
- Clinical Benchmarks
  - DM-1: Not smoking
  - DM-2: Regular aspirin use
  - DM-3: Glycosylated hemoglobin (HbA1c) value < 7.0% at most recent measurement
  - DM-4: Systolic blood pressure (SBP) < 130 mmHg and diastolic blood pressure (DBP) < 80 mmHg, using the mean of the two most recent measurements
  - DM-5: Funduscopic examination within the last year
  - DM-6: Measurement of urinary albumin excretion within the last year (or previous abnormal reading)
  - DM-7: If evidence of abnormal albuminuria, taking an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor blocker (ARB)
  - DM-8: Low-density lipoprotein (LDL) cholesterol < 100 mg/dl at most recent measurement

#### FOR HYPERTENSION –

- Domain of possible scores = {0,1,2,3}
- Clinical Benchmarks:
  - HTN-1: Not smoking
  - HTN-2: Regular aspirin use
  - HTN-3: SBP < 140 mmHg and DBP < 90 mmHg, using the mean of the two most recent measurements. (Note: Goal will be < 130/80 if concurrent diabetes)

**FOR HEART FAILURE –**

- Domain of possible scores = {0,1,2,3,4,5}
- Clinical Benchmarks:
  - HF-1: Not smoking
  - HF-2: Regular aspirin use
  - HF-3: History of an echocardiogram to determine left ventricular ejection fraction (LVEF)
  - HF-4: If evidence of left ventricular systolic dysfunction (LVSD; defined as LVEF < 40%), taking an ACEI or an ARB
  - HF-5: If LVSD, taking beta blocker

**SECONDARY OUTCOMES AND COVARIATES:**

- (1) Changes in individual components of the groups of clinical benchmarks listed above (e.g., change in proportion of regular aspirin users or non-smokers)
- (2) Estimated costs:
  - Total program cost
  - Emergency room visits and hospitalizations per diagnosis per year, comparing years before and after the intervention
  - Estimated avoided hospitalizations and emergency room visits per year
- (3) Patient and Provider Experience:
  - Patients who report “my medications are affordable”
  - Patients who report high satisfaction with care
  - Patient feedback on care guide experience
  - Patient feedback on including a family member or friend as part of the care team
  - Internal medicine residents with a favorable view of primary care as a career
  - Internal medicine residents who report they expect to practice as part of an integrated team during their careers
  - Clinic nurses who value care guides and report they are helpful
- (4) Process Measures:
  - Numbers and types of care guide interactions with patients
  - Successful and missed appointments per diagnosis per year
  - Understanding of implementation (e.g., what worked, what didn’t, challenges, changes)
    - Care guide conversations (focus groups, interviews)
    - Patient interviews
    - Provider interviews
- (5) Patient characteristics (e.g., race, insurance status, psychosocial factors)

**1.6 Potential Impact**

The pursuit of a new care paradigm that improves chronic disease management and promotes financial investment in primary care is a worthy endeavor for several reasons. First and foremost, patients will benefit from moving upstream in the continuum of care. Effective management of a chronic condition like diabetes or heart failure potentially exchanges an acute care experience for a primary care encounter, and this has **tremendous benefit for the patient and their family in terms of sustained quality of life**. Second, identifying sustainable clinic practices that shift some portion of the chronic disease management burden away from PCPs will only serve to reduce professional stress and

frustration. As current PCPs begin to experience substantive support, they will find their work more manageable and rewarding, and ultimately, **primary care practice will become a more attractive career option for new medical residents**. Third, if successful, this project will provide a working model and well-developed tools that will enable primary care providers in clinics across the country to tend to the needs of the chronically ill in manner that is more coordinated, consistent, effective, and personalized. Care with these attributes is a hallmark of the medical home concept<sup>8,9</sup> and therefore **this work will make an important contribution to the formation of an operational blueprint for constructing a medical home**. Lastly, this project will provide payers with relevant financial data about the cost and return on investment of a program that aims to address exorbitant acute care expenditures by promoting effective disease management and early intervention. In demonstrating that the current intervention can yield a positive return on investment, **fiscal results from this project will encourage payers to reconsider the persistent, disproportionate focus on acute care reimbursement**. With this in mind, the project team has been deliberate in the effort to design and test a low-cost intervention that requires a minimal addition of affordable staff.

The state of the U.S. primary care system is precarious and stabilization will only be achieved through unmitigated efforts at transformation and redesign. Testing and evaluating interventions using sound methodology and quantitative, clinical endpoints is a key activity in this process, and therefore, this project has the potential to contribute significantly to the accumulating knowledge base regarding transformational primary care redesign.



## 2. Background and Significance

### 2.1 Chronic Disease in the U.S. – Heart Failure, Diabetes, and Hypertension

Chronic illness in the United States has reached epidemic proportions. Approximately 125 million Americans live with at least one chronic condition and a majority (61 million) live with two or more chronic diseases<sup>4</sup>. The economic burden of chronic illness is staggering with medical costs related to chronic illness currently representing seventy-five percent of the nation's annual \$2 trillion in healthcare expenditures<sup>4,10</sup>. Because chronic disease disproportionately afflicts the elderly, the anticipated demographic shift occurring over the next few decades will inevitably exacerbate the toll chronic illness takes on the U.S. healthcare system, with projections of 157 million – half of the population – affected by 2020<sup>11</sup>.

Heart failure and diabetes are major contributors to the current scourge of chronic illness, and incidence rates continue to accelerate in tandem with an aging population. Rates of hospital discharges for heart failure increased 157% between 1979 and 2002 and there are an estimated 5 million Americans living with the condition<sup>12</sup>. More Medicare dollars are spent on heart failure than on any other diagnosis<sup>12</sup> and the American Heart Association estimates that in 2007 alone, \$33 billion was spent treating patients with heart failure<sup>13</sup>. Across all age groups, the prevalence of diagnosed diabetes has increased four-fold in the last half century and current estimates stand at 14.6 million, or 1 in 20 Americans<sup>14,15</sup>. In persons over age 60, the prevalence reaches an astounding 1 in 5. According to predictions by the Centers for Disease Control, 39 million Americans will be living with diabetes by 2050<sup>15</sup>. Hypertension is a ubiquitous comorbidity of both heart failure and diabetes, with 7 out of 10 heart failure patients exhibiting hypertension prior to their diagnosis, and 3 out of 4 diabetic adults having hypertension or controlled hypertension<sup>15</sup>.

The quality of life and life expectancy of individuals with heart failure, diabetes and hypertension can be improved with early diagnosis and effective therapy, yet evidence of the continued undertreatment of these conditions in the United States is considerable and disturbing. Despite significant advances in the knowledge about best practices for the treatment of heart failure, the syndrome confers an unacceptably high risk of disability and death. One-third of patients hospitalized with heart failure die within one year, and 6-month all-cause hospital readmission rates hover around 40%<sup>16</sup>. In addition to the 14.6 million Americans who have diagnosed diabetes, there are an estimated 6.2 million more who have undiagnosed diabetes<sup>17</sup>, and only 37% of diabetics achieve optimal glycemic control<sup>18</sup>. The World Health Organization has identified hypertension as the leading attributable risk for mortality in the world<sup>19</sup>. Between 1980 and 2000, the percentage of Americans receiving treatment for hypertension increased from 31% to 59%, but 30% of adults remain unaware of their hypertension, 40% of hypertensives still fail to receive treatment, and only 34% of treated hypertensives have achieved goal blood pressure levels<sup>20</sup>. A recent meta-analysis revealed that half of patients prescribed antihypertensive medications discontinue use within one year<sup>21</sup>. Clear, evidenced-based guidelines for these conditions exist and their successful achievement is known to ameliorate disease burden. To this end, the central aim of the proposed intervention is to maximize attainment of the most basic optimal care goals for these conditions. The clinical benchmarks targeted in this intervention have been defined prudently in accordance with best practice guidelines provided by the American College of Cardiology/American Heart Association (ACC/AHA) Task Force on Practice Guidelines for Heart Failure<sup>22</sup>, the American Diabetes Association<sup>23</sup>, and the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7)<sup>20</sup>.

## 2.2 Current State of Primary Care in the U.S.

Ambulatory care in the U.S. has become increasingly complex, specialized, and fragmented. Patients with chronic, complex health needs are often overwhelmed by the challenge of navigating between disparate settings, accompanied by an inadequate flow of patient information across an expansive continuum of care. From a provider standpoint, the stresses, inefficiencies, and excessive demands that characterize contemporary primary care do little to attract top-performing medical students and a deficiency in the number of physicians practicing primary care continues to tax the system. Advancements in medical technology and a widening pay gap between PCPs and specialists have created an intense focus on specialty and acute care over the past decade<sup>24</sup>, and the number of physicians practicing primary care is dwindling<sup>1,3</sup>. As physician numbers have declined, patient satisfaction has diminished and the coordination and quality of care afforded in the primary care setting has deteriorated. The following vignettes describe the recent, real-life experiences of two ANGMA-Medicine clinic patients. The examples clearly illustrate communication deficiencies and the detriment of uncoordinated care:

### Case Study #1

*David B. is a 67-year old gentleman with chronic dilated cardiomyopathy who has had multiple admissions to Abbott Northwestern for heart failure. After his most recent discharge, he was placed on higher doses of the key recommended drugs: the beta blocker metoprolol and the angiotensin system inhibitor lisinopril. For several months thereafter, Mr. B took his medication as instructed, was free from swollen legs and breathlessness, and was feeling very well. Mr. B then saw his cardiologist for a routine follow-up visit. His cardiologist recently had reviewed some results from the COMET (Carvedilol or Metoprolol) study, which demonstrated some modest benefit to using the new and more expensive beta blocker, carvedilol. Unbeknownst to Mr. B's PCP, the cardiologist recommended to Mr. B that he switch to carvedilol, and provided him with a thirty day supply of free samples. Mr. B diligently followed his cardiologist's instructions. He was fine until November, when he suddenly reappeared at Abbott Northwestern on an inpatient unit with a recurrence of florid congestive heart failure. Mr. B, like many Americans, became a victim of the Medicare Part D "donut hole". He had surpassed the calendar year medication coverage limit by November and stopped taking his medications because he was unable to afford them. The cardiologist switched Mr. B to a new drug, more expensive than his previous medications, and with only modest additional clinical benefit. Mr. B was embarrassed to admit that he could not afford to continue the new medication and instead took no medication and ultimately suffered a dangerous and costly recurrent episode of his condition. His cardiologist and PCP had not coordinated their care for him. While his PCP was aware of cost issues and in the past had registered him for a "free drugs by mail" plan for lower income people, his cardiologist remained unaware of this significant aspect of Mr. B's situation.*

### Case Study #2

*Esther D is a 78-year old woman with diabetic nephropathy. She was taking the angiotensin converting enzyme (ACE) inhibitor lisinopril, which has been shown to preserve kidney function and delay dialysis. Ms. D came to Abbott Northwestern with a broken hip and suffered a slight acute kidney injury related to the blood loss. Ms. D was seen by her nephrologist who discontinued her ACE inhibitor during her hospitalization, allowing her blood volume and kidney function to recover. She was given no instructions to restart her ACE inhibitor upon discharge. Ms. D was instructed to follow-up with her nephrologist after discharge, but failed to show for the appointment. Six months later, during a routine primary care visit, an ANGMA-Medicine*

*clinic resident discovered that Ms. D's creatinine level was elevated, indicating abnormal kidney function. Because Ms. D's care was not coordinated, she was not instructed to restart an essential medication after hospital discharge.*

*Whose responsibility was it to coordinate care for these patients? And how can patients safely navigate confusion that is induced by multiple providers and encounters?*

## 2.3 Barriers to chronic disease management in primary care

### System Barriers

The preceding examples clearly demonstrate that poor communication amongst providers is a fundamental barrier to effective chronic disease management. **Inter-provider communications** are rarely a well-defined component of systematic workflow and information exchange is all too often haphazard and insufficient. Another routinely cited barrier to the delivery of effective chronic disease management is **lack of adequate time during office visits**<sup>25</sup>. Considering that acute care takes precedence and cannot be postponed, there is often little opportunity to devote even a small amount of time to chronic disease management when patient encounters last on average only 18 to 21 minutes<sup>26</sup>. Chronic disease management can also be undermined by **physicians' perceived inability to effect behavior change** in their patients. Comprehensive chronic disease management often requires more than provision of information and physicians often lack the skills to provide meaningful motivational messages that will promote lifestyle changes and active self-management. One-third of PCPs in a recent survey said they would welcome the opportunity to receive training on how to encourage more effectively behavior modifications that promote cardiovascular health<sup>27</sup>. An interesting qualitative report on this subject describes the challenges that exist for physicians who attempt to impress upon the patient what they believe are important medical priorities while appreciating what is realistic and acceptable for the patient in terms of behavior change<sup>28</sup>. The **generalist-specialist income gap** mentioned earlier is another system barrier to chronic disease management. As fewer and fewer physicians practice primary care, patient volumes will increase and compromise the capacity and effectiveness of primary care. Finally, in **the current fee-for-service environment** there is a clear disincentive to practice effective, high-quality risk factor management in chronic disease patients who present in the ambulatory setting. Current reimbursement structures continue to reward the diagnostic and procedural activities performed in response to symptomatic disease and provide little to no financial incentive for efforts aimed at preventing adverse events in the asymptomatic patient. Healthcare administrators have identified "misalignment of financial incentives among health plans, care givers and patients" as the second most important barrier to improvement of clinical outcomes<sup>29</sup>.

### Patient Barriers

The numerous patient-based barriers to optimal chronic disease care are related to **knowledge, motivation, cost, and coordination**. Knowledge barriers exist when there is a general deficiency of information about aspects of the condition and the benefits of optimal care, and the patient simply doesn't understand what to do. This type of barrier often is rooted in health illiteracy or language and cultural issues. Motivational barriers can form when a patient is without substantive social support, has multiple, complex conditions, or when needs other than healthcare are more pressing – for example, food and housing in the case of impoverished patients. Motivation to self-care is compromised particularly in cases of substance abuse and depression, and when patients have not been consulted or involved in care-related decisions. Obviously many patients face economic barriers when they are



unable to afford medications, treatments and insurance. And finally, patients can be faced with logistical challenges related to coordinating care, such as lack of transportation or language barriers.

## 2.4 The Chronic Care Model

In response to the chronic disease management dilemma facing primary care, Dr. Edward Wagner and colleagues at Group Health Cooperative of Puget Sound continue to investigate how primary care might be redesigned to address the common barriers noted above. Dr. Wagner has developed a model, the Chronic Care Model<sup>30</sup>, which identifies six key elements to be considered in creating effective chronic illness care paradigms: (1) community resources and policies; (2) health care organization; (3) self-management support; (4) delivery system design; (5) decision support; and (6) clinical information systems. This model provides a theoretical framework for the current work, and aspects of the proposed intervention explicitly reflect four of the six chronic care essentials. Self-management support will be rendered as care guides invite patients to become the central voice in their care and complement patient efforts with navigational and informational support. The purposeful construction of care teams and clear delineation of tasks among team members in the intervention is an important element of a delivery system design optimized for chronic disease care. Using nationally recognized best practice guidelines in the highly visible care contract enhances decision support, and utilizing the system-wide EMR to manage data, monitor progress, and increase visibility of the care plan for each patient incorporates the clinical information systems component.

## 2.5 Why is the ANGMA-Medicine clinic a suitable environment in which to pilot the intervention?

The physicians, patients, and service model of the ANGMA-Medicine clinic at Abbott Northwestern Hospital make it an ideal setting in which to test the intervention. Physicians at the ANGMA-Medicine clinic are enthusiastic, think progressively, and will be excited to participate. The clinic is the practice home of our highly-respected Principal Investigator, Dr. Richard Adair, who enthusiastically brings to this work over thirty years of primary care experience, a passionate interest in residency training systems and sustainable primary care redesign, and demonstrated research skills. Most importantly, the young residents in this continuity clinic provide an impressionable training base for the PCPs of tomorrow. Through this work, we have an opportunity to impart cooperative, team-centered approaches to care and to cultivate a primary care environment that new residents will find professionally nourishing.

The patient population at the ANGMA-Medicine clinic is one rife with economic and cultural challenges. These patients face the full gamut of barriers to quality care, often simultaneously, so they are an ideal test group. Many of these patients are at the extreme negative end of the continuum in terms of their ability to self-advocate and navigate, and they are prone to a great many distractions related to difficult financial and personal situations. If the intervention proves successful in this population, there is a high probability the model will be effective in populations with fewer obstacles to care.

Lastly, the ANGMA-Medicine clinic is poised to implement the plan successfully because of its current service model. Existing systems will support the intervention, most notably the integrated EMR that connects the ANGMA-Medicine clinic's ambulatory care and the acute care provided at Abbott Northwestern Hospital. The clinic also has a smoothly functioning Prescription Assistance Program, adequate available office space, and resource support from the Allina Hospitals & Clinics system office (e.g., reporting, analytics, and publication support). ANGMA-Medicine clinic faculty physicians and

residents are integrally involved in maintaining the strong tradition at ANW of translating research into clinical practice and this project will build on that involvement.

## 2.6 How will this work ultimately advance public health?

Primary care is the foundation of healthcare, and if the precipitous decline continues, emergency rooms will become inundated, patients will experience poorer outcomes and increased rates of hospitalization, and healthcare expenditures are likely to soar<sup>2</sup>. Indeed, there is evidence that populations with robust, well-supported new models of primary care achieve better health outcomes and lower overall healthcare costs<sup>1,31</sup>. But despite this evidence, employers and insurers persist in their refusal to invest in primary care. These key players, comprising what Bodenheimer refers to as the healthcare “macrosystem”<sup>2</sup>, have done little to propel change or develop the sweeping reimbursement reform that is needed to reinvigorate the primary care system. Instead, the cause of primary care redesign to date has been championed almost exclusively by constituents at the “microsystem” level, namely primary care practices and physicians, many of whom realize the long-term implications of the looming crisis and are passionate about serving their patients well. There is a movement afoot to develop clinic-based care models that bolster the four pillars of high-quality primary care – access, continuity, comprehensiveness, and coordination<sup>8</sup>. But with reimbursement reform barely visible on the horizon, the overwhelming challenge is to develop models that are sustainable within a payment structure that continues to reward disproportionately specialist and acute care. The prompt elucidation of such models will both arm the healthcare system to quell the tide of chronic disease in the short-term and build the financial case for investment in primary care in the long-term.

A basic premise for success is to redesign the system so it is well-aligned with the needs of modern day health consumers, equipped to withstand the pressures of the escalating chronic disease burden, and congruent with evolving bundled payment mechanisms. The current project was conceived with precisely this premise in mind. The broad intent of this work is to promote care model reform by devising a coordinated, scaleable, and economically feasible model of care that yields demonstrable improvements in health outcomes and advances the paradigm of patients as active participants in their health. As the U.S. primary care system founders, redesign efforts such as the proposed intervention have the potential to demonstrate that investment in the “cultural” technology of primary care is as important as investment in cutting-edge medical technology.

### 3. Research Design and Methods

#### 3.1 Study Setting

A pilot test of the intervention (Phase I) will be conducted in the ANGMA-Medicine clinic where ANW internal medicine physicians and residents provide comprehensive primary care. During the second phase of the project, work will be expanded to facilitate the conduct of a randomized controlled trial in three additional primary care clinics: ANGMA-Center for Outpatient Care (Edina, MN), AMC-Woodlake (Richfield, MN) and AMC-Edina (Edina, MN). These particular clinics were selected expressly because they have a substantial patient base residing in the ANW service area. They also have demonstrated leadership, a strong history of quality improvement, and talented, receptive clinicians. Table 1 presents data related to the demographic composition, disease burden, and current attainment levels on several of the diabetes benchmarks for the four proposed clinic sites.

**Table 1.** Demographic and chronic disease characteristics of the four proposed clinic sites

|                          | ANGMA<br>Medicine Clinic<br>(Minneapolis) | ANGMA<br>Ctr for Outpatient Care<br>(Edina) | Allina Medical Clinic<br>Woodlake<br>(Richfield) | Allina Medical Clinic<br>Edina<br>(Edina) |
|--------------------------|-------------------------------------------|---------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <b>Demographics</b>      |                                           |                                             |                                                  |                                           |
| Active patients          |                                           |                                             |                                                  |                                           |
| > 18 yrs old (N)         | 5,449                                     | 9,765                                       | 19,731                                           | 12,813                                    |
| Female (%)               | 56                                        | 58                                          | 58                                               | 60                                        |
| Non-white (%)            | 32                                        | 11                                          | 18                                               | 14                                        |
| <b>Disease Burden</b>    |                                           |                                             |                                                  |                                           |
| Heart Failure (N)        | 130                                       | 183                                         | 371                                              | 211                                       |
| Diabetes (N)             | 366                                       | 716                                         | 1,428                                            | 740                                       |
| Hypertension (N)         | 833                                       | 3,468                                       | 4,471                                            | 2,179                                     |
| Distinct patients* (N)   | 881                                       | 3,433                                       | 4,838                                            | 2,378                                     |
| <b>Among Diabetics**</b> |                                           |                                             |                                                  |                                           |
| Non-smoking (%)          | 74                                        | 95                                          | 84                                               | 90                                        |
| Regular aspirin use (%)  | 81                                        | 90                                          | 96                                               | 96                                        |
| HbA1c < 7% (%)           | 48                                        | 63                                          | 59                                               | 63                                        |
| BP < 130/80 (%)          | 42                                        | 50                                          | 63                                               | 65                                        |

\* Number of unique patients across all three conditions (heart failure, diabetes, and hypertension)

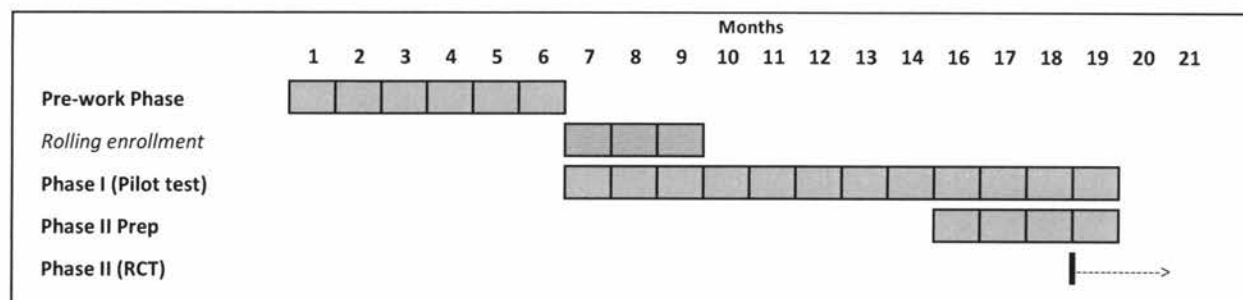
\*\* Data as of May 2008 for all Type I and Type II diabetics seen within the last 24 months

During the preparation of this submission, the Principal Investigator conducted interviews with a small sample (n=15) of randomly selected ANGMA-Medicine clinic patients with heart failure, diabetes and/or hypertension, to elicit spontaneous feedback on the general premise of the intervention. Interviews were conducted at the conclusion of routine clinic examinations during a one-week period in May 2008. The average age of patients was 64 (range = 31 to 84 years); twelve were native born Americans, and three were immigrants (Tibet, Togo, El Salvador). Questions were informal and open-ended and included queries about perceived value of the program, desirable characteristics of the care guides, and modes of contact. Patients were overwhelmingly receptive to the concept, with 100% indicating they thought the program would be valuable, either for themselves (n=12) or for others served by the clinic with less social support (n=3). There were no consistently strong opinions about the age or ethnicity of

the care guides, with most patients indicating that characteristics such as trust, knowledge, and sensitivity mattered more to them. Responses regarding frequency of contact centered around once per month, with the majority preferring telephone contact (14 of 15) and only 3 patients suggesting email. Patients were asked about potential names for the guides/coaches/coordinators; the project team was seeking a name that sounded authoritative but not hierarchical. Patients did not like “coach” and responded very positively to “guide”, so this was chosen. Clear, consistent themes in these conversations were (1) that patients are extremely eager to learn more about their conditions and best practice guidelines, and (2) that they do not need or want to be patronized. Patients are confident and capable, and are enthusiastic about the prospect of having a trusted individual who can provide them with resources and information. This effort on the part of the Principal Investigator clearly illustrates the intention of having patients and families integrally involved in this new care model from the beginning.

### 3.2 Project Timeline

The proposed project will consist of a purposeful pre-work phase, an initial pilot test at the ANGMA-Medicine clinic site (Phase I), interim analysis and decision making about success of the pilot (Phase II Prep Work), and upon demonstrated success, a subsequent randomized controlled trial (RCT) at three additional clinic sites (ANGMA-COC, AMC-Woodlake and AMC-Edina; Phase II). A graphical depiction of the project phases is included here and a brief description of each phase follows:

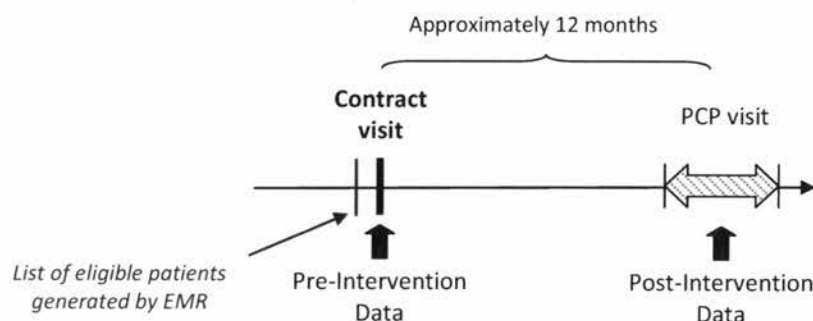


#### **Pre-work phase – Care guide role development & care contract integration**

During the pre-work phase, there will be an intense focus on formally developing the concept of the care guide. This will include articulating the inherent attributes and required competencies of the ideal candidate, identifying the specific responsibilities and activities of the care guide, and formalizing a comprehensive training curriculum. Additional details regarding this process are provided in section 3.4.1 of the proposal (“Pre-work Phase Tasks”). A second major undertaking will be finalizing the content and format of the care contract and integrating the contract and supporting tools into Allina’s EMR system. While the EMR already includes all fields necessary for monitoring specified care goals, the pre-work phase will allow the team to build and embed the contract, data consolidation algorithms, and tracking tools that collectively will form the electronic platform that will summarize and track progress towards clinical benchmarks. During this pre-work phase, patients, families, physicians, and clinic staff will play an important role in guiding intervention development via the Patient and Family Advisory Council and the Robina Project Advisory Board described in section 3.4.1. This crucial pre-work phase will require six months of effort and will extend from August 2008 through January 2009.

### **Phase I – Pilot test at the ANGMA-Medicine Clinic**

When all preparations for the intervention are completed, a 12-month pilot test will begin at the ANGMA-Medicine clinic. Immediately prior to initiating recruitment, the EMR data repository will be queried to obtain a list of all active patients at the ANGMA-Medicine clinic with documented diagnoses of diabetes, hypertension, and/or heart failure. Eligible patients will be contacted by staff and those agreeing to participate in the intervention will be scheduled for an initial contract visit, at which time the pre-intervention data will be reviewed, the patient will sign and receive a printed, portable copy of the care contract, and the care guide will begin coordinating support for the patient. Rolling enrollment of patients will occur during the first three months of Phase I (February 2009 through the end of April 2009). The aim is to enroll approximately 500 active patients at the ANGMA-Medicine clinic who will sign care contracts and work with care guides to overcome barriers to optimal care of their chronic conditions. Approximately 700 patients will be invited to participate in the intervention program, with an anticipated 75% response rate to the initial invitation. Each care guide will be assigned a panel of patients (approximately 120 to 160 patients per guide) and will provide ongoing support to patients for twelve months following enrollment. There will not be a fixed schedule in terms of frequency of guide-patient communications, but rather guides will be expected to maintain sufficient contact with each patient as to provide adequate support for clinic visits. For example, guides will contact patients by phone before and after PCP and specialist visits as needed, will be involved in the discharge proceedings of patients on their panel who are hospitalized at ANW, and will maintain a visible presence in the clinic to facilitate ad hoc barrier resolution. Details are provided in section 3.4.4 of the proposal (“Ongoing Support for Subsequent Care Encounters”). Patients will be followed for approximately twelve months and data from a PCP visit occurring in close proximity to the one year anniversary of the contract visit will serve as the post-intervention data. The project team will evaluate the impact of the intervention on improving the number of care goals met among participating patients using a simple pre-post analysis. The graphic below illustrates the data timepoints:



### **Phase II Prep Work – Interim analysis and decision-making for RCT**

In February 2010, or about one year after the first patient is enrolled, preliminary analyses using the most recent benchmark data available for each patient will be conducted to obtain a general sense of the efficacy of the intervention. Due to rolling enrollment, patients contributing to these initial analyses will have participated in the intervention for anywhere from 9 to 12 months. If initial analyses demonstrate a general trend towards improvement in the number of clinical benchmarks achieved, preparatory work for implementation of a full-scale RCT at ANGMA-COC, AMC-Woodlake, and AMC-Edina would commence. The project team expects to dedicate three months (February 2010 through April 2010) to refining and enhancing the intervention based upon pilot learnings and finalizing the design of the RCT and its various intervention arms. Patients and families will continue to provide



feedback regarding the model. During this phase, the three additional clinics will also begin the process of hiring and training care guides in accordance with project training materials and standards.

A formal RCT is an obvious extension of the initial project since randomization and a larger number of patients would provide a test of success far superior to the pilot. Key aspects of the care model could be evaluated very efficiently using multiple treatment arms in a large RCT, and complete discussion of potential considerations is provided in section 3.9 of the proposal ("Considerations for the RCT"). For example, of crucial importance to cost and feasibility is the guide-patient ratio. RCT treatment arms will be designed with varying ratios to inform how many care guides are needed per patient before the threshold for maximum effect is reached. The larger sample size will also facilitate subgroup analyses, allowing investigators to determine whether the intervention is particularly efficacious in certain subgroups of patients – for example, in those with low literacy or poor social support. Preliminary findings and process measures from the pilot will be scrutinized during this period of preparation for the RCT so that the ultimate design of the RCT maximizes the potential for significant and meaningful results. Some of these preliminary findings will be prepared for publication.

#### **Phase II – RCT at three additional clinics**

Phase II of the project, a RCT in three additional clinics slated to begin in May 2010, would occur only if the intervention showed merit during the pilot program. The three additional clinics would hire and train care guides using the approved materials and protocol. (Care guides from the pilot would remain in the ANGMA-Medicine clinic indefinitely.) Since these clinics are part of the Allina system, care contract functionality would be utilized in the medical records of patients in the intervention arms of the RCT. As stated earlier, the formal design of the RCT will be determined at a later date, but some of the anticipated considerations are presented in section 3.9 of this proposal.

### **3.3 The Intervention Approach**

#### **THE CARE GUIDE**

Oversight of the coordination, continuity, and quality of a patient's medical care is more often than not relegated to the patient or to the patient's family. In many instances, particularly in the case of a patient with a serious chronic disease, this task is simply beyond the capabilities of the patient and/or family members, often leaving the patient confused, passive, and apathetic about his or her care. Recognizing that patients who are unengaged in their care are more dissatisfied and experience poorer health outcomes, models are evolving in which patients receive support from a single individual who assumes the task of assisting them as they move through standard channels and processes of care. In its infancy, the concept produced the trademark "patient navigator" model, designed initially to address racial disparities in the diagnosis and care of people with cancer<sup>32,33</sup>.

Recent literature describes a host of sister entities to the patient navigator, known as "care coordinators", "health advisors", "health coaches", etc., that are being tested as a means to intensify and improve disease management in those with other chronic conditions, such as diabetes and heart failure<sup>34,35</sup>. Slightly different from cancer care patient navigators, individuals in these chronic disease management roles have focused on delivering comprehensive disease education and promoting lifestyle/behavior modification, and less on logistical barriers to care and system navigation. Typically, nurses or nurse practitioners with special training and certification in diabetes or heart failure care provide these extended care services, but with high patient volumes and lean primary care resources, this strategy is often not feasible. An innovative diabetes management program conducted within the

Group Health Cooperative of Puget Sound demonstrated significantly improved clinical outcomes, but the authors note that such success was achieved at a nurse:patient ratio of 1:250<sup>34</sup>. In an average-sized clinic with a panel of 1000 diabetes patients, this would mean hiring four additional skilled nurses – a fiscally unrealistic proposition for most contemporary primary care clinics. The delivery of optimal chronic disease care often is compromised, at its most basic level, by logistical barriers and system navigation challenges that could be addressed by non-clinically trained staff. **In the interest of producing an economically sustainable model of care, the current intervention will utilize non-clinically trained care guides whose fundamental goal will be to increase adherence to chronic disease care guidelines by:**

- (1) Empowering patients to take ownership of their own health and become active partners in their care
- (2) Assisting patients in developing an image of themselves as successful, competent, and healthy
- (3) Providing patients with practical guidance, skills, and tools that will assist them in circumventing or overcoming informational, financial, logistical, and motivational barriers to care
- (4) Giving patients a familiar, trusted point-of-contact in the healthcare system
- (5) Helping all members of the care team focus on the targeted clinical benchmark goals

Specific duties of the care guides are discussed in section 3.4 (“The Execution of the Intervention”), but key activities will include:

- (1) Making monthly contact via phone or email, to “check in” with patients, discuss medication adherence, review progress towards clinical benchmarks, and to inquire about any personal situations that may be impeding progress, etc.
- (2) Communicating with the patient before and after primary care encounters as needed, to facilitate agenda-setting, review the patient care contract and goals, assure the patients’ understanding of physician instructions, and prompt necessary treatment action
- (3) Becoming a material part of the inpatient experience by visiting patients prior to discharge, being aware of the transition plan, encouraging the patient to discuss the in-hospital stay with his or her PCP, and ensuring that the care contract is visible to hospitalists and other caregivers
- (4) Maintaining a visible presence in the clinic by staffing a Care Guide Help Desk – a convenient resource for ad hoc patient needs and questions

### ***Portrait of a Care Guide***

The success or failure of this intervention may rest squarely on the ability of the project team to identify and hire the “right” kind of people to serve as care guides in this intervention. Care guides will need to bring a series of intangible, interpersonal “soft skills” to the job – distinguishing personal qualities that enable them to gain respect, earn trust, and build relationships across a wide array of patients, family members, and care providers. In general, successful care guides must be able to manage encounters and communications with keen sensitivity, intellectual alertness, and an appropriate degree of confidence. They must internalize the notion that their mission is to help patients, not coddle them; that they are there to serve the patient, but not actively resolve problems on the patient’s behalf. They will need to

possess a self-assuredness that allows them to voice concerns with prominent physicians. Most importantly, they must maintain a fervent appreciation for the legal and ethical boundaries of their role, understanding that they are never to provide patients with medical advice.

Care guides will be required to handle a great many scenarios: from patiently but firmly reiterating to an elderly man the importance of daily aspirin use, to tactfully presenting transportation options to a patient with a string of missed appointments. From persistently nudging a proud middle-aged man who cannot find work to apply for prescription assistance, to empathetically validating the depressive symptoms of an older female patient who has recently lost her husband. Interpersonal encounters will be balanced with technical activities such as regularly interfacing with the patient's electronic medical record, communicating via email, and accessing online information and resources. These individuals will need to be astutely "high-tech, high-touch". The project team has carefully considered this crucial aspect of the intervention and produced an outline of personal attributes and requisite skills it believes would exemplify the ideal care guide candidate:

Personal attributes:

- Friendly and approachable
- Excellent verbal communication skills
- Energetic and enthusiastic
- Self-confident; able to work with physician team without feeling intimidated
- Adept at eliciting patient concerns and feedback; will ask patients what they think, rather than just telling them what to do
- Psychologically capable of understanding the legal/ethical limits of their role
- Recognizes that the aim is to assist patients and families in developing the skills and confidence to help themselves
- Astute awareness of human nature and environmental forces – can recognize why a patient is struggling; attune with holistic barriers to success.
- Content to see others work for themselves; does not encourage or enable dependency; will not unduly internalize a patient's failure as their own personal or professional failure.
- Appreciates the subtle distinction between being persistent and being a pest
- Possesses a bit of "life experience", to enhance credibility and increase the chances of finding some common ground with each patient.
- Innate ability to elicit cooperation; respectfully acknowledges divergent viewpoints
- Demonstrates integrity and discretion; will maintain the highest data privacy standards
- An apt and eager pupil

Skills:

- Some college level coursework
- Bilingual as needed for the populations served (for instance, English-Somali and possibly English-Spanish for Phase I)
- Proficiency with computers, email, and the internet
- Interest in health care; must become comfortable with medical and pharmacologic terminology
- Able to commit to at least one year of employment (and preferably longer)

### **Care Guide Training Curriculum and Philosophy**

Care guides will participate in a training course developed and administered by the Project Coordinator and the Principal Investigator. Wherever possible, instructors will be knowledgeable personnel drawn from appropriate resources across Allina Hospitals & Clinics (e.g., Excellian Support, IHH). The training curriculum will be developed formally during the six-month pre-work phase of the project, but will consist of the following basic modules:

(1) Overview of primary care

*Concept of primary care “medical home”; appropriate use of emergency departments and urgent care; care guidelines and why they are important; understanding barriers to adherence; medical terminology; very basic HF-DM-HTN-specific pharmacology; general overview of the research design and aims of the Robina project*

(2) Medical/legal aspects of their role

*HIPAA and privacy laws; absolutely NO medical advice; basic understanding of Medicare/Medicaid, particularly as it relates to drug benefits*

(3) Resource and referral mechanisms

*Online pharmacy information; summary of important drugs including trade and generic names; current retail information for medications – where to fill prescriptions most affordably; prescription assistance programs; ANW resources: IHH, smoking cessation, social worker, dietician, diabetes educators, specialists*

(4) Techniques for motivating patients to self-care

*How to assess degree of motivation in an individual; understanding motivational styles (e.g., “move away” vs. “move towards”); strategies for determining what motivates someone to change or maintain change; identifying value-based intrinsic and extrinsic motivators; how to leverage values and elicit motivation that is self-propelling; behavior modification techniques; behavioral contracting*

(5) Message delivery techniques and communications

- *Sensitivity training -- understanding the role of addictive behaviors, poverty, depression, isolation, aging, multiple medical conditions, culturally appropriate behaviors and expectations*
- *Phone and interpersonal etiquette*
- *Barriers to adherence (knowledge, cost, motivation, logistics) and how to overcome: shopping for inexpensive drugs, seeking help when needed*
- *Effective communication skills for dealing with the range of members on the care team (e.g., the elderly relative vs. the cardiologist); how to advocate; team-building strategies*

(6) Excellian (EMR)

*General instruction on functionality, interface, and communication mechanisms; work flow; accessing and printing the care contract; electronic data privacy issues; tracking and documenting patient contacts*



## THE CARE CONTRACT

The electronic care contract to be developed and tested in this intervention represents the marriage of two clinical care concepts: **behavioral contracting** and **shared care**. Behavioral contracting between physicians and patients is a common component of interventions designed to improve patient adherence to treatments or promote beneficial lifestyle changes<sup>36-38</sup>. Basic behavior theory suggests that formalizing a written, binding agreement of behavioral expectations related to the care of a patient serves to elevate the patient's commitment to following treatment regimens or modifying behavior. This strategy has been effective in some<sup>38,39</sup> but not all studies<sup>37</sup>, and it is clear that more high-quality research is needed in this area. Goal setting and action planning, two important strategies which facilitate adoption of healthy behaviors<sup>40</sup> are inherent elements in traditional patient-physician contracting.

The second concept, shared care, has been defined as "the joint participation of PCPs and specialty care physicians in the planned delivery of care for patients with a chronic condition, informed by an enhanced information exchange over and above routine discharge and referral notices"<sup>41,42</sup>. Theoretically, shared care harmoniously combines the expertise of specialty care and the continuity and "whole patient" focus of primary care – a dimension of coordination that is frequently absent in today's fragmented, discordant health system. Recognizing the importance of coordinated care for patients with chronic disease, a recent movement has produced shared care models that facilitate enhanced inter-provider communications. The advent of EMRs has served to accelerate this movement via the provision of a platform for information access and exchange. The concept of an electronic shared care plan, a document containing crucial information about a patient's care and goals that can be accessed by providers across the continuum of care, has been realized as part of the Whatcom County, WA, Pursuing Perfection Project (<http://www.patientpowered.org/>).

As part of the current intervention, an electronic care contract and supporting electronic tools will be used both to motivate patients to self-care and to support care guides and care team members as they nudge patients, in a uniform manner, towards attainment of specific benchmark goals for optimal care. The care contract will have two components – declarative contract language with supporting signatures, and a summary report detailing the patient's status (achieved or not achieved) on each of the clinical benchmark goals. Physicians and care guides will be able to review and print the contract at each encounter, providing the patient with tangible, consistent feedback on progress. Providing the patient with a printed, portable copy of the contract is a key feature of the concept. The exact content, format, language, and electronic interface of the contract is to be developed during the six-month pre-work phase of the project, and will be informed separately by patient and physician focus groups and an Allina psychologist with expertise in diabetes care. A preliminary concept draft of the care contract for a patient with diabetes is included as Appendix A.

The care contract itself will be complemented by secondary tools that will enable care guides and physicians to track patient progress and document encounters. For example, for purposes of care guide patient panel management and tracking, an on-demand report containing information such as patient names, provider names and contact information, dates of contact, date of next scheduled appointment, etc., will also be created. The care contract and reporting tools will be fully integrated into the patient's existing EMR. Below are some sample screenshots of current EMR functionality in Allina's Excellian system demonstrating this capability.

The Care Contract embedded within Excellian.

**Stf. Nine** 21 y.o. male (7/26/1986) Allergies: Type PCP Alerts: INS MyChart Rec. Do  
2200000471 Sulfa (sulfo... None Amc Buffalo FYI HM! No billing informati... Inactive

**New letter for the encounter of 5/22/2008** [Close]

From: PORTZ, MELISSA Reason for letter: Letter comments:

90% [Icons] [More] Arial 10 B I U S A Template: CARE CONTRACT

**ALLINA HOSPITALS AND CLINICS  
CARE CONTRACT**

Patient: Nine Stf DOB: 7/26/1986

Care Contract for Hypertensive Heart Disease and Diabetes Management

This agreement allows us to work together in good faith, as partners in creating an appropriate treatment plan.

1. My care plan will help me manage my ... I understand that my ...
2. I agree to ...
3. I agree to take the medication ...
4. I agree to ...
5. I agree to ...
6. I will keep regular appointments with my provider....

This agreement is effective until \*\*\* or for no longer than 1 year from date signed.

Patient signature (or parent/guardian if under 18): \_\_\_\_\_ Date: 5/22/2008 Nine Stf

Provider's signature: \_\_\_\_\_ Date: 5/22/2008

(type in phrase for your name with credentials \*\*\*)

**Routing**

| Recipient | Modifier |
|-----------|----------|
|           |          |

Add PCP Add My List Build My Lists Clear All

☐ Route to sender

**Routing comments**

[Icons]

Print Mark as Sent and Accept

The patient "Problem List", viewable in emergency departments and inpatient settings as well as outpatient settings, indicates that the patient has a care contract. Additional notes can be added such as "If patient is admitted to hospital, please contact Care Guide at 000-000-0000".

|                |                                                                                                       |          |                                                   |           |                                             |             |
|----------------|-------------------------------------------------------------------------------------------------------|----------|---------------------------------------------------|-----------|---------------------------------------------|-------------|
| SnapShot       | Problem List                                                                                          |          |                                                   |           |                                             |             |
| Chart Review   | <input type="text"/> <input type="button" value="+ Add"/> <input type="button" value="+ CodeSearch"/> |          | <input checked="" type="checkbox"/> Full Comments |           |                                             |             |
| Flowsheets     |                                                                                                       |          |                                                   |           |                                             |             |
| Results Review |                                                                                                       |          |                                                   |           |                                             |             |
| Allergies/Preg |                                                                                                       |          |                                                   |           |                                             |             |
| History        |                                                                                                       |          |                                                   |           |                                             |             |
| Problem List   |                                                                                                       |          |                                                   |           |                                             |             |
|                | ▶ DIABETES MELLITUS TYPE I [250.01]                                                                   | Priority | Class                                             | Noted     | Resolved                                    | Updated     |
|                | Has signed Care Contract on file, please see SnapShot                                                 |          |                                                   | 5/22/2008 | <input checked="" type="checkbox"/> Resolve | ! 5/22/2008 |
|                | ▶ HYPERTENSIVE HEART DISEASE W HF [402.91]                                                            |          |                                                   | 5/22/2008 | <input checked="" type="checkbox"/> Resolve | ! 5/22/2008 |
|                | Has signed Care Contract on file, please see SnapShot                                                 |          |                                                   |           |                                             |             |

Html-based "Snapshot" functions like a cover page in the medical record. The user will have the option to click on Care Contract. A report will display with hyperlinks to the scanned contract.

**Snapshot**

← Snapshot HealthCare Directive Care Contract Report: Snapshot

**Problem List**

DIABETES MELLITUS TYPE I

HYPERTENSIVE HEART DISEASE W HF

**Allergies**

SULFA (SULFONAMIDES)

**Health Maintenance** → Overdue ⚠ Due On ⚡ Due Soon

→ TETANUS BOOSTER ADULT 07/26/2006

**Medications**

Prescriptions Show facility-administered medications

FISH OIL 500 MG-300 MG CAP

METOPROLOL 50 MG TAB

MULTIVITAMIN TAB

**Immunizations Injections**

Influenza, Inactivated (Age ≥=3 years) 5/22/2008

## THE CARE TEAM

Patients with complex, chronic illness are often the most time and resource intensive for PCPs. They require frequent appointments, ongoing testing and monitoring, self-care between visits, and in many instances, multifaceted post-discharge transitional care. There is widespread recognition that within the confines of the brief patient encounters that are the hallmark of primary care practice, physicians can no longer single-handedly deliver comprehensive, best practice care for high-need patients. In recent years, this dilemma has lent itself to experimentation with care models in which nurse case managers, medical assistants, licensed practical nurses, lay health workers, or other personnel assist physicians in caring for chronically ill patients. Given the sensibility and success of these team-based interventions, the optimal role and configuration of care teams in chronic disease management is now a central theme in the debate on primary care redesign<sup>43-45</sup>. Discussion, evaluation, and insight have produced a generalized model of care known as the teamlet model, in which non-physician staff are able to extend care beyond the standard fifteen minute physician-patient encounter by first, buffering the traditional visit on either side with pre- and post-visit sessions, and second, providing sustained follow-up care between clinic visits via routine contact with the patient<sup>46</sup>. The ultimate goal is to reduce physician workload while simultaneously increasing the amount and quality of attention that the patient receives. To extend this work, Bodenheimer also elucidates five features that distinguish highly effective clinical teams<sup>45</sup>: (1) having goals that are unambiguous and measurable; (2) presence of clinical and administrative systems that support the work of the team; (3) clear division of labor; (4) training; and (5) solid communication framework and processes.

**The proposed intervention is based upon the teamlet approach**, with PCPs and care guides working cooperatively to achieve clinical benchmark goals in their patients with diabetes, heart failure, and hypertension. Care guides will consult with patients both before and after clinic visits as needed, and maintain regular contact with patients via phone between clinic encounters in support of self-care efforts. An adaptation for the current intervention is the addition of a key family member or friend to the primary care team. Many aspects of the proposed intervention address the aforementioned components of high-performing teams. For example, the primary outcomes for the project are stated in terms of clinically meaningful and measurable outcomes (e.g., change in the number of clinical benchmarks for optimal diabetes care attained by the patient). With regard to systems, the EMR will function elegantly as both a clinical and administrative platform for the work, with the care contract and secondary tools built specifically to support the efforts of the entire care team. Division of labor among the team members will become more explicit as the role and training curriculum for the care guides is developed in conjunction with physicians during the pre-work phase of the project. Care guides will receive appropriate training, protocols, and oversight to ensure they are well-equipped to manage all facets of their role. The Project Coordinator will mentor the care guides, regularly evaluating their work and helping them hone their skills and improve performance. The expectation regarding communication channels and standards is that there is much to be gleaned from “on-the-ground” experience, particularly during the pilot phase, and streamlined processes will evolve accordingly.

In thinking about care teams, consideration must also be given to the broader collection of clinicians that provide care beyond the primary care setting. For patients living with chronic illness, points-of-care are sprinkled across the healthcare continuum – often from primary care to specialty care to acute care and back to primary care. Regrettably, care rendered across disparate providers and settings often is disjointed, deficient, and uncoordinated, resulting in compromised safety, adverse clinical outcomes, and diminished patient satisfaction. While the aggregation of a patient’s extended care team evolves naturally, true teamwork must be forged purposefully. In the case of extended care teams, communications, coordination and shared decision-making often must traverse physical and professional space, and this poses unique challenges. The current intervention proposes use of an



electronic care contract as a central underpinning for increased communication and therapeutic goal alignment across each patient's extended care team. Before the pilot begins, relevant groups of potential extended care team members (e.g., hospitalists, specialists, diabetes educators) will be convened and provided with a project overview, an explanation about the role of the care guides, a statement about expectations and benefits, and some brief training on the care contract and associated workflow. Then when the project is underway, providers across the system will be cued via the EMR to review a patient's care contract at the point-of-care, increasing the likelihood of coordinated action and professional exchange.

Two final considerations related to care teams deserve mention. First, the nuclear care team formed within the patient's primary care practice in this intervention will provide a centralized human core that promotes accountability, focus, responsiveness, and support from all members of the care team. The nuclear care team and the involvement of patients in the design of the intervention have the potential to produce care that is truly patient-centered, an indisputable feature of high-quality care, and a step in the direction of a patient-centered medical home as championed by the American College of Physicians<sup>47</sup>. Secondly, there are many PCPs for whom a treasured part of medical practice has been the development of long-term therapeutic alliances with patients. They intrinsically relish teamwork and a holistic approach to patient care, and have been disappointed that these dimensions have all but vanished under the constant pressure to see complex patients in a short visit. The care teams we envision could be a mechanism for re-establishing this kind of gratification for practicing physicians and attracting medical students with these affinities to primary care careers.

### 3.4 The Execution of the Intervention

#### 3.4.1 Pre-work Phase Tasks

##### **Project Coordinator**

The Project Coordinator will be hired by the Principal Investigator with advice from the project team and clinical staff and will assume responsibility for the majority of the pre-work phase activities required for implementation of the pilot test in the ANGMA-Medicine clinic (outlined below). A primary assignment will be the hiring and training of the care guides with assistance from the Principal Investigator. During the pilot test, the Project Coordinator will provide ongoing mentoring and oversight of the care guides and assume responsibility for all daily operations of the pilot study. The project team has generated the following preliminary list of desired qualifications and personal attributes of the Project Coordinator:

- registered nurse with 5+ years in clinical practice
- significant managerial, team-building, and training/teaching experience
- working knowledge of clinical research methods
- well-developed computer skills
- familiarity with outpatient medicine
- experience working with resident physicians
- ability to multi-task and prioritize
- strong interpersonal skills; ability to work collaboratively
- comfortable working with inner-city patients (low-income, non-English speaking)

##### **Care Guide Training Curriculum**

Prior to the pilot study, care guides will attend a (two-week) comprehensive training course. The general content of the training has been outlined in section 3.3 and the Project Coordinator and the Principal

Investigator will formalize the curriculum with significant input from physicians, pharmacists, Excellian support staff, IHH staff, community-based training programs, and other appropriate individuals with special expertise. A wide variety of practical training elements will be incorporated including written protocols, scripts, and educational materials, instructional videos, role playing exercises, mock interviewing, and applied Excellian training. Instruction will be provided by the Project Coordinator, ANGMA physicians, and other knowledgeable personnel drawn from appropriate resources across Allina Hospitals & Clinics (e.g., Excellian Support, IHH, ANW Human Resources).

### **Care Contract Development**

Staff from Allina's Clinical Decision Support team will work closely with the Project Coordinator, Principal Investigator and other experts to design the care contract as described in section 3.3 ("The Care Contract"). Excellian Support staff will also assist during the pre-work phase by developing and delivering brief training sessions on functionality, interfacing with the contract, adapting workflow, and printing options.

### **Resource and Referral Materials**

Care guides will maintain an inventory of printed resource and referral materials for distribution to patients – educational information, pamphlets, business cards, transportation schedules, listings, etc. The Project Coordinator will collect, modify, and update materials as needed.

### **Clinic Modifications**

In preparation for the pilot, modifications will be made to the physical space at the ANGMA-Medicine clinic. "Bricks and mortar" projects will include reconfiguration of existing desktop workspace to accommodate four care guides and the Project Coordinator, installation of office furniture, telephones, and computer kiosks in the lobby that will form the Care Guide Help Desk, multilingual signage for the Help Desk, and carpeting that helps organize patient flow and delineates the Help Desk space as separate from the waiting area. The Principal Investigator has evaluated the current clinic space and confirmed that these needs can be met without major structural renovations.

### **Convene Extended Care Team Providers**

The Project Coordinator and ANGMA-Medicine physicians will identify the pool of medical providers who have a high likelihood of interacting with ANGMA-Medicine patients as part of extended care teams. Examples include cardiologists at Minneapolis Cardiology Associates (MCA), endocrinologists, ANW emergency department physicians, diabetes educators at the ANW-Diabetes Center, and pharmacists at nearby Allina Community Pharmacies. Prior to the pilot, the Principal Investigator and/or Project Coordinator will make brief presentations to these groups during standing meetings to introduce the project, outline general expectations, discuss communication preferences and issues, demonstrate Excellian functionality related to the care contract, field questions, and establish a "teamwork" mentality.

### **Working Groups**

As a means to obtain direct feedback and input from patients during the pilot phase of the project, a **Patient and Family Advisory Council** will be formed. Council members will be 10-20 patients (and family members) from the ANGMA-Medicine clinic who have diabetes, heart failure, or hypertension and who volunteer to convene regularly with the Project Coordinator and share the health consumer perspective. Through the Patient and Family Advisory Council, a whole new view on this work will emerge, and feedback from patients and families will inform methods, strategies, and language. The project team is adamant about demonstrating to patients that we invite them in as full partners and value the concerns

and contributions of patients and their families. A second working group, the **Robina Project Advisory Board**, will consist of the Principal Investigator, the Project Coordinator, some or all of the care guides, representatives from different physician groups, clinic nurses, care guide training faculty, and members of the extended care team. The charge of this group will be to address operational, communication, and capital issues, provide feedback on successes and failures, explore new directions and strategies, and serve as a representative body for extended care team members participating in the project.

#### **Communications with Institutional Review Board (IRB)**

Since Phases I and II of this project include a research component, the Principal Investigator will request a full review of the proposed intervention from the Allina Hospitals & Clinics IRB. The Principal Investigator will cooperate fully with the IRB to understand patient protection issues (e.g., the relevance of HIPAA releases for extraction of historical data), to make certain that participants are informed fully of the expectations of the project/research, and to ensure that the rights and privacy of patients, staff, and providers are protected diligently during the intervention.

### **3.4.2 Identification of Eligible Patients and the Invitation to Participate**

At the conclusion of the six month pre-work phase, the data repository of Allina's EMR will be queried to obtain a list of all active patients at the ANGMA-Medicine clinic with diagnoses of diabetes, heart failure, and/or hypertension. At the same time, all available cross-sectional data related to status on the clinical benchmarks targeted for intervention also will be extracted from the EMR, providing a baseline status for each patient. An introductory letter will be sent to each patient, describing the new program, inviting the patient to participate, and informing the patient that they will be receiving a phone call from a care guide who will provide them with additional information and answer questions. This introductory letter will be signed by the patient's PCP and will include the specific name of the care guide who has been assigned to the patient by the Project Coordinator. Patients and care guides will be language matched whenever possible and introductory letters will be written in Somali and Spanish as needed. Care guides then will begin contacting patients by phone and scheduling contract visits.

### **3.4.3 Initial Clinic Visit and Commitment to the Care Contract**

Patients will be enrolled formally during an initial 40-minute, Robina-funded clinic encounter at the ANGMA-Medicine clinic, referred to as the contract visit. The Project Coordinator, the care guide, and the patient will participate in the contract visit, and the patient's PCP will make a brief appearance during the encounter whenever possible. (This will be facilitated by scheduling the contract visit immediately before or after a regular clinic visit when feasible.) The patient will be provided with an overview of the program and asked to read and sign a statement documenting informed consent. The contract visit will include:

- General information about the patient's chronic condition(s)
- Discussion of best practice benchmarks and the benefits of attaining them
- Review of current status on benchmarks and selection of which ones to target first
- Development of a treatment plan
- Introduction to resources and referral mechanisms, including information on controlling medication costs

In addition, the care guide will review the components of the electronic care contract, demonstrating for the patient how it resides in the EMR and how providers can access the contract. The care guide will invite the patient to be an active participant in his or her care, and will ask the patient to demonstrate the intention to cooperate by signing the contract. The patient then will be given two printed copies of the contract – one to keep at home, and one in a transportable format which can be presented to care providers, not all of whom use Excellian. The patient will be instructed to carry the contract with them and present it to all care providers. The care guide also will introduce the Care Guide Help Desk as an all-purpose resource for the patient, and reiterate that the patient can contact the care guide at any time with further questions or concerns.

#### **3.4.4 Ongoing Support for Subsequent Care Encounters**

Care guides will each be assigned a group of about 150 patients during the pilot study with whom they will maintain regular contact. The frequency of contact will be determined mutually by patient and care guide, with input from the PCP. Many of these contacts will occur before and after appointments, to help set agendas and ensure adherence with physician instructions. A summary of every patient contact will be documented and sent to the PCP's Excellian in-basket.

##### **Pre-Visit Contact**

- Contact occurs through telephone call or e-mail, depending on patient preference
- Identify agenda for the visit with the PCP
- Review the pieces of the contract, specifically unmet benchmarks

##### **Post-Visit Contact**

- Contact occurs about one week after visit, through telephone call or email, depending on patient preference
- Inquire about what the patient garnered from the visit with the PCP
- Confirm that they understood instructions; “closing the loop”
- Have they started making recommended changes? How successful have they been?
- Did they purchase their medications? Are they taking the medications? If not, what are the barriers – and can I help?
- Have they scheduled appointments as instructed by the PCP?

##### **Hospital discharge facilitation**

Care guides will generate a daily list of ANGMA-Medicine clinic patients who have been admitted to ANW or the ANW emergency department.

- Conduct a face-to-face visit with the patient at ANW, providing a familiar “point-of-contact” for the patient
- Learn about transition/discharge plans.
- Ensure that the care contract is visible to physicians prescribing medications and clarify medication instructions with the patient, with particular emphasis on when to resume chronic disease medications that may have been stopped or changed in the hospital
- Facilitate post-discharge appointments with PCP and/or specialists



### **Care Guide Help Desk**

Care guides will staff a Help Desk in the waiting room of the ANGMA-Medicine suite to assist all patients – regardless of their participation in the program – with ad hoc questions. Clinic physicians, nurses, and receptionists will be encouraged to refer appropriate questions to the Help Desk, thereby generating a sense of teamwork and freeing up some of their time for the daily tasks of patient care. This provision of tangible, day-to-day support will foster physician acceptance and endorsement of the program. When not assisting patients, the care guides will conduct computer and phone work (non-HIPPA protected) in full view of patients to provide a sense of easy access. This visible presence sends two important messages to patients – (1) primary care is my “medical home” and (2) I can take an active part in my care and access the system easily. Here are some examples of the types of questions the Help Desk might receive:

- *Where can I get this medication at the lowest price?*
- *How do I apply for subsidized insurance or free-drugs-by-mail programs?*
- *My doctor says I need to see a specialist. Can you help me make the appointment?*
- *Do you have the number I should call for Abbott’s quit smoking program?*
- *Can you tell me how to get to the nearest Allina Community Pharmacy?*
- *Do you have any information about diabetes that is printed in Spanish?*
- *I’d like my husband to carry a copy of my care contract. Can I get another print out?*
- *Can you help me with transportation?*

### **3.4.5 Interaction of nuclear care team members**

Although the teamlet model of care has a sound theoretical foundation, implementation in practice will require flexibility and creativity. Refinement of communication standards and workflow processes will require some trial and error Plan-Study-Do-Act (PDSA) cycles. The initial intention in the proposed intervention will be to pair care guides with specific physicians so they begin to forge unique cooperative relationships and interdependence. To further enhance continuity, care guides will be required to commit to the position for a minimum of one year and they will meet as a group on a regular basis to share information and synchronize approaches and resource/referral patterns. As part of the training curriculum, care guides will be given practical instruction on effective team-building strategies. Care guides periodically will reinforce with physicians and patients the concept of shared patient-physician responsibility and will help everyone see themselves as part of a team with a common goal.

How to involve the key family member or friend is at this point conjectural since formally engaging this additional member as part of the nuclear care team is an innovative and untested aspect of this design. During the initial contract visit, the patient will be asked to consider and nominate an individual for this important role. Ideally the person will be a stable, supportive, companion who generally models healthy behaviors and attitudes. However, there may be instances in which the patient’s choice is recognized by the care guide or PCP as being less than optimal (e.g., the chain-smoking sister of a patient who has smoking cessation as a goal). In these situations, the care guide tactfully may encourage the patient to reconsider and nominate an alternative.

### 3.5 Data

#### 3.5.1 Hypotheses and Measures

##### Primary Outcomes

The primary outcome of the proposed study is the **change in the absolute number of disease-specific clinical benchmarks attained**. The associated primary hypothesis is that **patients participating in the intervention will experience an increase in the total number of clinical benchmarks achieved over the pilot test period**. (The null hypothesis is that patients will experience either no change or a decrease in the number of clinical benchmarks achieved.)

While there are potential indirect benefits of the proposed study (e.g., positive view of clinics by outside organizations; change in system priorities and orientation towards primary care; change in payer behavior regarding value of primary care), the primary and secondary outcomes identified and measured will focus on clinical outcomes and their associated costs, as well as patient and provider experiences and perceptions. These outcomes were selected to reflect the focused nature of the proposed intervention and to allow for a meaningful understanding of change in immediate outcomes. Clinical benchmarks included in the proposed study are identified below:

##### FOR DIABETES –

- Domain of possible scores = {0,1,2,3,4,5,6,7,[8]} (*8 for those with abnormal albuminuria*)
- Clinical Benchmarks
  - DM-1: Not smoking
  - DM-2: Regular aspirin use
  - DM-3: Glycosylated hemoglobin (HbA1c) value < 7.0% at most recent measurement
  - DM-4: Systolic blood pressure (SBP) < 130 mmHg and diastolic blood pressure (DBP) < 80 mmHg, using the mean of the two most recent measurements
  - DM-5: Funduscopic examination within the last year
  - DM-6: Measurement of urinary albumin excretion within the last year (or previous abnormal reading)
  - DM-7: If evidence of abnormal albuminuria, taking an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor blocker (ARB)
  - DM-8: Low-density lipoprotein (LDL) cholesterol < 100 mg/dl at most recent measurement

##### FOR HYPERTENSION –

- Domain of possible scores = {0,1,2,3}
- Clinical Benchmarks:
  - HTN-1: Not smoking
  - HTN-2: Regular aspirin use
  - HTN-3: SBP < 140 mmHg and DBP < 90 mmHg, using the mean of the two most recent measurements. (*Note: Goal will be < 130/80 if concurrent diabetes*)

##### FOR HEART FAILURE –

- Domain of possible scores = {0,1,2,3,4,5}
- Clinical Benchmarks:
  - HF-1: Not smoking
  - HF-2: Regular aspirin use

- HF-3: History of an echocardiogram to determine left ventricular ejection fraction (LVEF)
- HF-4: If evidence of left ventricular systolic dysfunction (LVSD; defined as LVEF < 40%), taking an ACEI or an ARB
- HF-5: If LVSD, taking beta blocker

### **Secondary Outcomes and Covariates**

There are a variety of secondary outcomes and covariates that will be evaluated in an effort to characterize the study population, to better understand the change in clinical benchmarks, to estimate the cost of the program and its downstream cost impact, and to assess patient and provider experiences and the process of implementation. An intentional focus on one primary outcome and hypothesis dictates that no secondary hypotheses are stated—secondary outcomes are identified and measured for the purposes of understanding the intervention and preparing for the randomized trial in Phase II. Psychosocial characteristics, such as depression or perceived stress, may be measured during the pilot with the express intent of understanding how to operationalize their measurement in diverse populations with the potential for including them more formally as secondary outcomes in the Phase II RCT. Secondary outcomes and covariates for the proposed study are outlined below:

- (1) Changes in individual components of the groups of clinical benchmarks listed above (e.g., change in proportion of regular aspirin users or non-smokers)
- (2) Estimated cost:
  - Total program cost
  - Emergency room visits and hospitalizations per diagnosis per year, comparing years before and after the intervention
  - Estimated avoided hospitalizations and emergency room visits per year
- (3) Patient and Provider Experience:
  - Patients who report “my medications are affordable”
  - Patients who report high satisfaction with care
  - Patient feedback on care guide experience
  - Patient feedback on including a family member or friend in their care
  - Internal medicine residents with a favorable view of primary care as a career
  - Internal medicine residents who report they expect to practice as part of an integrated team during their careers
  - Clinic nurses who value care guides and report they are helpful
- (4) Process Measures:
  - Numbers and types of care guide interactions with patients
  - Successful and missed appointments per diagnosis per year
  - Understanding of implementation (e.g., what worked, what didn’t, challenges, changes)
    - Care guide conversations (focus groups, interviews)
    - Patient interviews
    - Provider interviews
- (5) Patient characteristics (e.g., race, insurance status, psychosocial factors)

### **3.5.2 Data Collection**

The majority of clinical outcomes will be gathered through queries of the EMR. Only a portion of secondary outcomes can be obtained through the EMR; the remaining secondary outcomes will be



gathered through surveys or qualitative data collection techniques (e.g., key informant interviews, focus groups). Outlined below are the data sources and availability for the primary and secondary outcomes:

|                                                                                                                                       | Available in EMR<br>(Reportable Field) | Source of Data                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Components for Primary Outcomes</b><br>(and secondary outcome individual clinical benchmarks)                                      |                                        |                                                                                                                                                                                                                                      |
| Disease status<br>(Heart Failure, Diabetes, Hypertension)                                                                             | Yes                                    | Physician enters manually into Problem List                                                                                                                                                                                          |
| Smoking status                                                                                                                        | Yes                                    | Clinic nurse enters upon rooming (Vital Signs), or physician enters into Problem List                                                                                                                                                |
| Medications<br>(Aspirin, ACEI, ARB, Beta-blocker)                                                                                     | Yes                                    | Clinic nurse or physician enters into Medication List                                                                                                                                                                                |
| Laboratory Measurements<br>(HbA1c, Urinary albumin, LDL cholesterol)                                                                  | Yes                                    | Data from lab results automatically populate fields                                                                                                                                                                                  |
| Blood Pressure<br>(Systolic and Diastolic)                                                                                            | Yes                                    | Clinic nurse manually enters at each visit (Vital Signs)                                                                                                                                                                             |
| Funduscopy exam                                                                                                                       | Yes                                    | Completion of examination is recorded in the Problem List for diabetic patients                                                                                                                                                      |
| Left Ventricular Ejection Fraction                                                                                                    | Yes                                    | Echocardiogram report from imaging is available in the Chart Review - Procedures                                                                                                                                                     |
| <b>Secondary Outcomes</b>                                                                                                             |                                        |                                                                                                                                                                                                                                      |
| Emergency Room Visit                                                                                                                  | Yes                                    | ED visit types identified by searching Excellian for MRNs (medical record numbers) of enrolled patients                                                                                                                              |
| Patient Hospitalization                                                                                                               | Yes                                    | Inpatient and observation visit types identified by searching Excellian for MRNs of enrolled patients                                                                                                                                |
| Total program cost                                                                                                                    | No                                     | Cost estimates derived from cost accounting (previous year's data) and actually incurred expenses                                                                                                                                    |
| Patient Feedback<br>- Medications are affordable<br>- Satisfaction with care<br>- Care guide experience<br>- Family/Friend experience | No                                     | Confidential survey mailed to patients and family; Patient and Family Advisory Council member focus group conducted during pilot; invited key informant patient and family member interviews conducted periodically throughout pilot |
| Resident Feedback<br>- Positive view of primary care<br>- Feel part of a team                                                         | No                                     | Confidential survey mailed to residents; focus groups with active resident participants conducted during last quarter of pilot                                                                                                       |
| Clinic Staff Feedback<br>- Utility of care guides<br>- Impact on clinic workflow                                                      | No                                     | Focus groups with active clinic staff, focus groups with care guides, and key informant interviews with care guides, all conducted periodically during the pilot                                                                     |
| Number/type of care guide encounters                                                                                                  | Yes                                    | Types and frequency of care guide visits and identified by queries of medical records of each enrolled patient                                                                                                                       |
| Appointments kept per year                                                                                                            | Yes                                    | "Complete" appointments identified by queries of medical records                                                                                                                                                                     |
| Appointments missed per year                                                                                                          | Yes                                    | "Incomplete" (visit not complete or cancelled) appointments identified by queries of medical records                                                                                                                                 |
| Patient Characteristics                                                                                                               | Yes/No                                 | Some available in EMR; as needed, others will be ascertained using interviews or questionnaires                                                                                                                                      |

### **Assessment of Medication Use**

Concerns about outcomes related to medication adherence often are raised because of the discrepancy that can exist between a physician prescribing medication and a patient regularly using the medication as instructed. Patients in this intervention will have the option to fill prescriptions at non-Allina pharmacies, and therefore monitoring adherence using refill rates is not a viable strategy. However, Allina has a robust medication reconciliation process, facilitated by Excellian, which requires care providers throughout the system to verbally confirm use of patient medications at numerous points-of-care. Providers and nurses verify medications and retire from the patient medication list any medications they confirm patients are no longer actively taking. This process certainly does not eliminate measurement error, but it should reduce it. The project team is also cognizant that patients may over- or under-report medication use due to participation in the study (i.e. the Hawthorne effect), but expect that the relationships formed within the nuclear care team will promote candor.

### **Data Privacy and Security Assurance**

When information collected during the contract visit becomes part of the EMR, these data will become subject to all the privacy, confidentiality, and protection offered by Allina's EMR system which is bound and protected by HIPPA. All Allina EMR data are strictly protected by password-only access, secure data archival practices, and data encryption. Patient data that resides in the EMR will be accessed only by physicians, clinic staff, and care guides, and project investigators will not require access to data on an individually identifiable basis. Data to be analyzed by the investigators of this project will have been stripped of personal identifiers and all analyses will be conducted in aggregate.

***The next three sections, 3.6 Analysis, 3.7 Project Oversight, and 3.8 Challenges and Limitations pertain specifically to Phase I ("Pilot test at the ANGMA-Medicine clinic"). The expectation is that the analysis, project oversight and challenges will be modified/expanded as the project progresses into Phase II ("RCT at three additional clinics").***

## **3.6 Analysis**

### **Sample Size**

The proposed study is designed to allow for enrollment of all patients identified as having hypertension, diabetes mellitus, and/or heart failure. There are approximately 881 eligible patients in the ANGMA-Medicine clinic currently. Assuming that 10% of these patients are inactive, approximately 705 patients remain for potential study participation. While the study team anticipates a high response rate to the initial invitation to participate (i.e., 75%, yielding 529 patients enrolled), even a more conservative estimate of response (i.e., 50%, yielding 352 patients enrolled) generates a sufficient number of patients to detect meaningful changes in benchmarks.

Using an assumption that any given benchmark (or set of benchmarks) might be met 50% of the time and seeking a 95% chance of detecting a 10% change (2-tailed) in benchmark attainment (or set of benchmarks), the proposed study would require a minimum of 325 patients. This sample size calculation is based upon a paired t-test analysis, comparing pre-pilot and post-pilot benchmark attainment.

### **Primary Outcomes**

Analysis of primary outcome data will occur in three steps. First, outcome data will be examined and cleaned as necessary. Second, outcome data will be studied to determine distributions. Where outcome data are normally distributed, a paired t-test will be performed to determine whether post-pilot benchmark attainment is statistically different from baseline benchmark attainment. Preparations for the Phase II RCT will commence contingent upon detecting at least mildly significant differences in benchmark attainment (i.e.,  $p < 0.20$ ). Where outcome data are not normally distributed, a Wilcoxon signed rank test will be performed to determine whether post-pilot benchmark attainment is statistically different from pre-pilot benchmark attainment.

Sub-group analysis will be performed, not with the aim of demonstrating statistical significance, but with the aim of understanding how benchmark attainment may have differed across different groups of patients. Sub-group analysis will follow the above primary outcome analysis plan, focusing on differences in benchmark attainment by:

- Patient cultural background
- Care guide
- Magnitude and types of patient barriers
- Patient health literacy

### **Secondary Outcomes**

Changes in individual clinical benchmarks (e.g., regular aspirin use, non-smoking status) will be evaluated in a manner similar to the analysis plan for the primary outcomes – using paired t-tests where variables are normally distributed and Wilcoxon signed rank tests where variables are not normally distributed. Again, analysis of secondary outcomes will not be undertaken for purposes of establishing statistical significance, but rather to better understand the successes and challenges of the pilot.

Program costs will be examined to determine the total direct cost of the program and expressly describe the line-item costs of implementing such a program. Costs of emergency department or inpatient visits incurred, and an estimate of avoided visits, will provide information about the potential positive economic benefits of better management of chronic conditions.

Analysis of patient and provider experience data, as well as qualitative process measures, will be conducted in accordance with the data collection method used. Where data are collected through surveys, descriptive statistics and full response frequencies will be used to understand the experience of patients and clinic staff and providers. Where focus groups and key informant interviews are the method, transcribed notes will be reviewed for key themes, key quotes, and messages that will inform the randomized trial in Phase II. Quantitative care guide encounter data will be analyzed using basic descriptive statistics. All quantitative analysis will be performed in SPSS 16.0 and all qualitative analysis will be performed using NVivo 8.0.

## **3.7 Project Oversight**

### **Project Management**

The proposed intervention will be guided by the Robina Project Advisory Board as described in section 3.4.1 (“Working Groups”). The Project Advisory Board will meet biweekly to develop and implement the project plan. In addition, Drs. Jon Christianson and Doug Wholey will co-lead an evaluation team that will meet monthly to coordinate measurement and analytic activities for the project. The evaluation

team will include epidemiologists, data analysts, and report writers from Allina's Center for Healthcare Innovation and the Quality, Measurement and Analysis unit in the Office of Clinical Excellence.

### **Care Guide Team Meetings**

Throughout the pilot test, the Project Coordinator will convene monthly group meetings with the care guides. Given the uncharted nature of this work, the care guides will be provided with training and tools and then be unleashed in the living laboratory of the ANGMA-Medicine clinic. It is crucial therefore, to provide the care guides with regular opportunities to seek guidance and exchange ideas. These monthly meetings will provide a forum in which the care guides can discuss challenges and trends, share strategies, provide feedback, and generally offer guidance and support to one another. In conjunction with these meetings, structured continuing education will be provided to keep the care guides abreast of updates in process, resources, and broad project goals. For example, a pharmacist might educate the care guides about changes in retail pricing or new forms of financial assistance. Every effort will be made to maintain the unique patient-guide pairing at every encounter, but creating a unified and well-connected body of care guides also serves to minimize disruption and reduce patient anxiety when substitutions become necessary.

### **Key Personnel**

The budget and justification for key personnel and all other project related expenses are included as Appendix B. A description of key personnel is included below and curricula vitae are available upon request.

#### ***Executive Sponsor: Penny Wheeler, MD***

As the Chief Clinical Officer (CCO) of Allina Hospitals & Clinics, Dr. Penny Wheeler directs Allina's clinical quality and improvement agenda. She is responsible for ensuring best-of-practice approaches, ongoing innovation and excellence in care, and supporting the development and retention of effective clinicians. Born at Abbott Northwestern Hospital, she is a board-certified obstetrician/gynecologist and continues her practice at Women's Health Consultants in Minneapolis. She has served as president of the medical staff at Abbott Northwestern Hospital. Prior to assuming the position of CCO in June 2006, Dr. Wheeler served on the Allina Hospitals & Clinics Board of Directors where she chaired the Quality Committee and was recognized as Minnesota Board Member of the Year for her governance leadership on patient care quality. She is an Institute for Healthcare Improvement-trained quality improvement specialist. Dr. Wheeler also serves on the Board of VHA Inc., a national healthcare alliance that connects not-for-profit healthcare organizations and facilitates quality improvement and supply chain efficiencies for its members. Her educational background includes an undergraduate degree with honors from the University of Minnesota, and a doctorate of medicine degree from the University of Minnesota Medical School. Dr. Wheeler will devote a portion of her time to this work, providing executive guidance, facilitating system-wide communications, and when positive outcomes are achieved, ensuring that the demonstrated new care models are advanced in the organization, inform public healthcare policy, and propel other care redesign initiatives.

#### ***Principal Investigator: Richard Adair, MD***

Dr. Richard Adair is board-certified in internal medicine and currently co-leads the physician team at the ANGMA-Medicine clinic. Dr. Adair has been practicing primary care for 36 years and brings a tremendous amount of practical expertise and insight to this work, including skills in management of both patients and employees in a primary care medical office. He worked in a private practice clinic in Minneapolis for 25 years and has been with the ANGMA-Medicine clinic for eleven years. He has an intimate knowledge of the barriers confronting inner-city patients and a solid appreciation for how to



facilitate behavioral change in both patients and physicians. He is deeply committed to teaching and has served as a full-time faculty member in the ANW Internal Medicine Residency Program for the past eleven years. In addition, he has held an academic appointment in the University of Minnesota's Department of Medicine for over 30 years, currently as Adjunct Professor of Medicine. He also served as a Major in the US Army Medical Corps during the Vietnam War. His 16 peer-reviewed publications reflect his professional interests, which include immigrant health, urban medicine, systems for improving chronic disease care in a residency training clinic, and prescription drug affordability. Dr. Adair received an undergraduate degree with honors from Harvard College, and an MD from Harvard Medical School. Dr. Adair will serve as the Principal Investigator, devoting 20% of his time during the first three years of the project and assuming ultimate responsibility for all aspects of the design and implementation.

***Co-Investigators: Bryce Pierson, MD; Bryan Post, MD; Peter Lund, MD***

Drs. Bryce Pierson and Bryan Post are both board-certified practicing internists at the ANGMA-Center for Outpatient Care and will serve as co-investigators on this project. Both have served as Chief Resident of the internal medicine residency training program at Abbott Northwestern Hospital; Dr. Pierson in 2003-2004, and Dr. Post in 2006-2007. In this role, they were responsible for conducting case conferences and grand rounds, teaching and supervising the work of residents, and staffing inpatient units as attending physicians. Dr. Post received his undergraduate degree with honors from Carleton College, and his MD from the University of Minnesota. He co-authored a peer-reviewed article "Access to Health Care: Differences between insured and uninsured patients in South Minneapolis" during his internal medicine residency. Dr. Pierson received his bachelor's and doctorate degrees in chemical engineering from Iowa State University and the University of Minnesota, respectively, and then earned an MD with honors from the University of Minnesota Medical School in 2000. Dr. Pierson currently holds an Adjunct Associate Professorship in the Department of Medicine at the University of Minnesota. He has extensive clinical research expertise in the area of human natural killer cell activity and has first-authored 8 peer-reviewed publications on the topic. Dr. Peter Lund is a board-certified internist who works with Dr. Adair at the ANGMA-Medicine clinic. Dr. Lund received his undergraduate degree from Brown University and his MD from the University of Minnesota. After his residency at Abbott Northwestern Hospital, he was recruited as a full-time teacher in his residency program. Dr. Lund has a special interest in immigrant medicine and medical care for the underserved, and a strong interest in health policy. After his internal medicine residency he traveled in Asia for nine months.

These three young physicians have a keen interest in the future of internal medicine. They read widely about medical and social issues, understand that major transformation is coming to the practice of medicine, and want to help shape that change. They are leaders in their respective clinics and future leaders in the Minneapolis medical community. Drs. Pierson, Post, and Lund will each devote 5% of their time during various phases of the project, overseeing project activities at their respective sites, participating in intervention development, and contributing to publication and presentation efforts.

Other co-investigators from the two additional AMC clinics that will participate in the RCT will be named at a later date.

***Evaluation Co-Director: Jon Christianson, PhD***

Dr. Jon Christianson is an economist and the James A. Hamilton Chair in Health Policy and Management at the University of Minnesota. He has substantial experience evaluating and merging impact and process data from large-scale organizational redesign efforts. Pertinent to this project, he has published a book on chronic illness models of team care. Dr. Christianson has been a senior investigator on the

Robert Wood Johnson Foundation's Community Tracking Study for ten years, and is one of four senior investigators combining and evaluating qualitative and quantitative data for Robert Wood Johnson's Aligning Forces for Quality Initiative. This work included fielding a national consumer survey designed to collect data from individuals with chronic illness regarding interactions with the healthcare system and the degree of their personal involvement in managing their care. Dr. Christianson earned his B.A. in mathematics and economics from St. Olaf College, and his master's and doctoral degrees in economics from the University of Wisconsin – Madison. He will devote 15% of his time for the duration of the project, providing oversight of the collection and analysis of all process data for the project.

***Evaluation Co-Director: Doug Wholey, PhD***

Dr. Doug Wholey is a professor of Health Policy and Management in the School of Public Health at the University of Minnesota. He is one of the foremost organizational sociologists in the United States and the United Kingdom. Dr. Wholey's current research examines social networks in medical clinics and his expertise more broadly includes healthcare organization and performance. He is a visiting professor at the National Primary Care Research and Development Centre at the University of Manchester, England, where he is contributing to the examination of team integration and patient outcomes in the general practice clinics of England's National Health System. Dr. Wholey is a member of the steering committee for the Center for Chronic Disease Outcomes Research, a VA Health Services Research and Development Center of Excellence. His educational background includes an MBA in management from the University of California, Berkeley, and a PhD in organizational behavior and industrial relations from the Haas Graduate School of Business Administration also at UC-Berkeley. Dr. Wholey's research and expertise will provide a strong foundation for the evaluation of care team evolution and dynamics in this intervention. He will devote 15% of his time for the duration of the project, co-directing the evaluation team with Dr. Christianson.

***Health Economist: Robert Town, PhD***

Dr. Robert Town is an associate professor of health economics at the University of Minnesota's School of Public Health (Division of Health Policy and Management). Dr. Town's expertise lies in the areas of health economics, industrial organization and applied econometrics. He focuses on understanding competition in healthcare and understanding its impact on quality. He received both his master's and doctorate degrees in economics from the University of Wisconsin – Madison. Dr. Town will devote 5 % of his time for the duration of the project, serving as one of the co-investigators of this research. He will focus specifically on cost and return on investment analysis.

***Research Consultant: Jeffery Dusek, PhD***

Dr. Jeffery Dusek became the Research Director for Abbott Northwestern Hospital's Institute for Health and Healing in 2007. Prior to this assignment, he was an Instructor in the Department of Medicine at Beth Israel Deaconess Medical Center, Harvard Medical School, and Director of Behavioral Sciences Research at the Benson Henry Institute for Mind Body Medicine, Massachusetts General Hospital. He has been a member of several review panels of Integrative Medicine at the National Institutes of Health. He also served as co-Principal Investigator for an 8-year CDC-funded program grant examining the effectiveness of clinical programs to reduce cardiovascular diseases such as coronary artery disease and metabolic syndrome. Dr. Dusek received his bachelor's degree from St. John's University and his doctorate in psychology from Stony Brook University. He will devote 5% of his time to this project, lending his expertise on clinical research methods and analysis as well as providing guidance regarding aspects of the design related to promoting self-managed health and wellness.

**Care Guide Training Faculty: Patricia Vitale, LICSW**

Ms. Patricia Vitale is a licensed clinical social worker and currently serves as the Inpatient Services Manager and Director of Strategy and Development at Abbott Northwestern Hospital's Institute for Health and Healing. She is the co-founder of The Meta Institute, a school for Therapeutic Coaching® in Minnesota. Relevant to the current project, the Therapeutic Coaching® curriculum she instructs includes techniques and theories in the areas of team-building and leadership, motivational counseling, learning styles and addictive behaviors. She has extensive experience working with a variety of populations in the field of motivation and readiness for change. She possesses skills in managing inpatient and outpatient clinics and incorporating complementary modalities into mainstream mental health services. Ms. Vitale has a master's degree in social work. She will devote 15% of her time for the duration of the project, lending her expertise to the development of the care guide training curriculum and assuming responsibility for instructing care guides in training modules related to motivating patients to self-care, message delivery techniques and communications.

**Clinical Decision Support Coordinator: Melissa Portz, RHIT**

Ms. Melissa Portz is a registered health information technician and a clinical analyst with Allina's Clinical Decision Support team. Her work centers around optimizing the decision support tools in Excellian to facilitate evidence-based practices. Prior to her position with CDS, Ms. Portz was part of the EMR implementation team at Allina, providing design input, project management and support. In 2007, she completed the 10 x 10 program in Biomedical Informatics through Oregon Health and Sciences University and has been an active member of the American Health Information Management Association since 1996. She will devote 50% of her time during the pre-work and pilot phases of the project, acting as the clinical decision support coordinator for the project and leading the development and technical implementation of the electronic care contract.

**Other Support**

The role of the Project Coordinator has been outlined in section 3.4.1 and this individual will be named during the pre-work phase. Allina's system office, specifically the Quality, Measurement and Analysis unit (within the Office of Clinic Excellence) and the Center for Healthcare Innovation, will offer extended informational and logistical support during the project. A number of individuals across these units possess highly-developed skills in relevant areas such as data extraction and report writing, epidemiology, clinical research and analytic methods, quality and process improvement, and medical writing.

**3.8 Challenges and Limitations****Hiring the "right" individuals to serve as care guides and identifying and developing the appropriate care guide training will be crucial to success.**

In confronting this challenge, we will rely upon the experience of the Principal Investigator and conduct a diligent search of the existing literature on patient navigators. The Principal Investigator's thirty-plus years in primary care practice and his extensive experience with hiring and managing clinic staff will help him identify individuals likely to perform well in this role and integrate into this clinic setting. We also will conduct a scrupulous review of the existing literature on similar concept models (e.g., patient navigators, lay health workers) to inform the development of the job description, competency and personal attribute requirements, and training curriculum for the care guide position. Dr. Thomas Bodenheimer has provided the project team with an existing curriculum outline for consideration. IHH staff also will provide useful insight. Because we are trying to develop and test a new kind of employee for a medical office, we will report in detail our



experiences regarding hiring and training the of the care guides, salary requirements, and how many patients one care guide can effectively serve, so this information is widely available for others to use.

**The care contract must be developed and seamlessly integrated within the EMR.** During the substantial pre-work phase, Allina's Clinical Decision Support (CDS) staff will devote considerable time and resources to the electronic care contract build, including collaborative content development and careful study of its impact on workflow. CDS staff are extremely competent and have successfully supported the development of many such tools for previous organizational initiatives. Existing functionality can accommodate the care contract and associated algorithms as demonstrated by the preliminary screenshots included in the proposal. With the exception of the to-be-hired care guides, virtually all providers who will participate in the project have been using Excellian for several years, are familiar with the interface, and are accustomed to periodic upgrades and modifications to the system. To ensure smooth integration, training for all care team members will be developed and conducted during the pre-work phase.

**The ANGMA-Medicine clinic presents a challenging group of multi-ethnic and economically disadvantaged patients.** Residents and physician faculty have good continuity with the patients at the ANGMA-Medicine clinic and have been working with this inner-city population for years. In general, patients are loyal to this clinic and report satisfaction with their care in periodic surveys. Physicians and clinic staff are familiar with barriers to care in this population, and the difficulties in attending to these barriers in the current time- and resource-restricted environment. We will address the linguistic diversity of the patient population by requiring at least one of the care guides to be bilingual (English-Somali). The ANGMA-Medicine clinic has a Prescription Assistance Program to help patients with financial needs, and an in-house social worker is available to assist with psychosocial or interpersonal challenges and to facilitate functional independence.

**Success of this work will depend partially on patient behavior change and adherence, so care guides will be trained in motivational techniques.** Many ANGMA-Medicine clinic patients are often unclear about how to initiate and sustain behavior change, similar to patients nationwide who struggle with lifestyle modification and treatment adherence. Involving staff from the IHH who will train care guides in behavioral modification counseling and motivation theory will improve the probability that the intervention can effect change in patient adherence. Moreover, involving a close family member or friend as part of the care team is a strategy aimed at ensuring that patient accountability for self-care permeates beyond the clinic walls and into the patient's social environment.

**The intervention will be subject to self-selection bias and the Hawthorne effect.** The project team is well aware that no amount of intervention effort can assist some patients who fundamentally are unwilling to change. Since patients may decline to participate in the intervention, the group who elects to work with care guides may over-represent those who are more inclined to try new things and have a propensity for change. To minimize this self-selection bias, we intend to cast a wide net and enroll as many patients with the targeted diagnoses as possible, using existing relationships with PCPs and nurses when necessary. Our goal is to improve outcomes for this entire patient population. The project team also appreciates that patients may temporarily modify behavior due to increased attention, or may over-report or under-report behaviors (e.g., smoking and medication use) to the care team. The project team remains optimistic that the establishment of genuine, supportive relationships amongst the care team members will promote honesty and forthrightness, minimizing the so-called Hawthorne effect.

**Cultural shift will be difficult to achieve across a wide group of practitioners including specialists and hospitalists not affiliated directly with the ANGMA-Medicine clinic, but a systematized approach should provide necessary support.**

Patient care teams can be very fluid entities, and coordination will be tested as providers shift in and out over time as dictated by patient needs. The care guides must be up to the task of constantly informing new care team members of the project, expectations, and the patient's goals. To this end, care guides will take a very active role in provider communications – it will not be left passively to chance. By design, the patient also has a role to play in terms of care coordination. By committing to share the care contract with all providers, patients will serve as an iterative voice in their own care, echoing the messages of the care guide at every encounter. The fact that the care contract resides in the EMR unambiguously brings “systemness” to the approach as the patient's goals and progress are readily visible across the system. If the intervention is executed successfully and this triad – care guide voice, patient voice, and electronic care contract – becomes firmly entrenched in the care delivery system, a cultural shift to care that is more patient-centered can be achieved.

**The intervention must be executed within the scope of an existing clinic culture and done so with minimal disruption.**

Logistical issues will be a reality for most clinics in the broader community so it must be demonstrated that the intervention can be operationalized within the confines of limited resources and existing physical space. For instance, to keep the approach as pragmatic as possible, the availability of clinic workspace at the ANGMA-Medicine clinic played a part in the determination of the number of care guides that will be employed during the pilot phase. Secondly, the intervention must be implemented with minimal disruption to existing workflows. Feedback from clinic staff will be solicited regularly in an effort to discern whether care guides are truly helpful or perceived as interfering with standard clinic workflow (i.e., “gumming up the works”). To this end, we have conceived the role of the care guide as separate from the roles of traditional clinic employees (reception, rooming, triage nursing). Adjustments will be made accordingly throughout the pilot study until clinic personnel concur that the care guides are an enhancement to clinic operations and improve patient care.

**Pitfalls**

The project team is aware that they are developing and testing a new care model. Despite our explicit attempt to build this model on the foundation of preceding work, and to plan this intervention carefully with advice from a wide variety of experts, failure is always a possibility when trying something new. Reasons for possible failure that we can foresee include: (1) care guides may need a nursing background to be effective; (2) clinic physicians and nurses may reject this model as too much change all at once; (3) we may be unable to hire the kind of individuals we seek at the salary we propose; (4) care guides could vacate their positions before they have time to become effective; (5) enrollment may be less than we predict yielding an inadequate sample size; (6) specialists or others may resist the teamwork paradigm. If we encounter significant barriers during Phase I (the pilot study), we will work actively to eliminate them in planning for Phase II. If the intervention does not show evidence of success in Phase I and barriers to success seem excessive, we would not proceed with Phase II and would seek to publish a report describing negative results.

### 3.9 Considerations for the RCT

Following successful implementation of the pilot project (Phase I), the project team will initiate pre-work for Phase II, a randomized controlled trial of the proposed intervention. The pre-work for Phase II will provide an opportunity to make course corrections between Phase I and Phase II and will include:

- Review of successes and challenges of the pilot study, especially those related to care guide characteristics, the electronic care contract, involvement of family members, and care team communication and involvement
- Appreciation for types of patients who were easy to enroll and activate in the pilot vs. those patients who were more challenging to enroll – and consideration of new strategies for engaging patients with a more challenging profile
- Revisions of care guide qualifications and training, as determined by the above review—the project team may, for instance, decide to hire certified medical assistants (CMAs) for the RCT
- Revision and expansion of the electronic care contract, again as determined by the above review; enabling EMR care contract capabilities in the RCT clinics
- Hiring of care guides and supervising staff for RCT clinics
- Finalization of research design, patient randomization scheme, and implementation plan

Preparation for the RCT will involve finalization of the key research questions to be answered during Phase II. Initially, however, the RCT will be designed to elucidate **the optimal ratio of care guides to patients and the optimal characteristics of care guides (i.e., qualifications and salary)**. The RCT design might also address questions about the appropriate composition of care guide patient panels in terms of patient complexity – in other words, determining the ideal distribution of more vs. less complex patients (with regard to both disease and personal characteristics) for each care guide, and how to assess risk and risk stratify patients more broadly. The RCT may also be formulated to allow for investigation about whether setting more aggressive benchmarks yields more rapid and sustainable change in patient clinical outcomes.

The project team currently envisions an RCT in three additional clinics—ANGMA-COC, AMC-Edina and AMC-Woodlake. Patients with hypertension, heart failure and/or diabetes mellitus will be randomized to one of 5 intervention arms—

- Control group—patients will participate in a 40-minute chronic condition visit to discuss guidelines, with no care guide follow-up
- 1:200 care guide: patient ratio group (*note that the pilot study is designed for a 1:140 – 1:160 care guide: patient ratio in a more challenging patient population*)
- 1:300 care guide: patient ratio group
- 1:400 care guide: patient ratio group
- 1:500 care guide: patient ratio group

Obviously these ratios may be adjusted based upon findings from the pilot phase. Approximately 10,649 patients are currently eligible for the RCT (see Table 1, page 16). Assuming a response rate of 50%, 5,324 patients will participate in the RCT—yielding between 1,200 and 1,800 patients per arm. All patients who are eligible will be invited to participate.

The project team anticipates submitting an updated protocol to the Robina Foundation in April 2010 containing sufficient detail (similar to the current proposal) to operationalize the RCT.

### 3.10 Dissemination & Future Direction

#### Dissemination

Dissemination of information about the pilot and RCT will occur through traditional means of sharing research results, along with purposeful connections to payers and members of the broader healthcare community. The project team will provide annual progress reports to the Robina Foundation, apprising the Board of progress and learnings. These updates will also be shared with the Patient and Family Advisory Council, all project personnel, physicians and investigators across the four clinics, as well as other key stakeholders (e.g., Allina Medical Clinic and Allina Hospitals & Clinics leadership). In addition, the project team will engage in periodic mass communications (i.e., Care Guides in the Primary Care Office Briefs) to key contacts in healthcare organizations and other stakeholders likely to be interested in the status and progress of the project. As expected, the project team will produce peer-reviewed publications and present findings at local and national scientific and professional meetings. Finally, the project team will share interim and final progress reports with local and national payers, with the ultimate expectation that the data derived from the project may generate evidence to advocate for change in reimbursement policies aligned with the project's approach and findings.

#### Future Direction

One of the key future activities of the Robina project team will be to consider when and how to invite a member (or members) of the payer community to participate in this endeavor, and specifically to test the proposed intervention against standard practice with a subset of the payer's patients. The intention of this partnership would be to develop and understand the impacts of partnerships between providers and payers that leverage the care model and the suite of tools and approaches developed with this funding (e.g., ANGMA or Allina Medical Clinics might receive some percentage of payer's realized savings from one year of the program in exchange for proof of concept and development work).

The project team anticipates that Phase II will inform Phase III, a multi-faceted initiative to improve primary care at Allina, and ultimately Phase IV, an effort to expand these new models to a broader group of ambulatory environments. While the pilot work and Phase II are centered on improving health outcomes in patients with targeted chronic conditions, Phases III and IV will aim to merge synergistically learnings from the current work and lessons from other initiatives to improve the delivery of care in a broad range of ambulatory settings. Phase III may, for example, include other primary care providers (e.g., pediatricians, family practice physicians), move beyond the targeted conditions into additional areas (e.g., chronic obstructive pulmonary disease, asthma), expand care teams to include additional members (e.g., nurse practitioners) and additional tasks, involve patients in home monitoring, and offer additional behavioral services. Phase IV may involve the movement of new primary care models to the remaining Allina ambulatory structure, as well as active engagement of local and national groups to promote and extend the model beyond the organization.

In terms of health information technology advancement, Phase IV will coincide with Allina's intent to interconnect affiliated independent physician groups and patients via expansion of the Excellian platform. Penetration of Allina's EMR into the broader healthcare market is essential to providing a seamless exchange of information and point-of-care decision support across all providers. Although in its infancy, this type of effort is already underway, as evidenced by Allina's current piloting of Novo, an economical middleware solution that can link affiliated physician groups to the Allina system. A related strategic priority for the organization is the functional maturation of the electronic personal health record. The Excellian system currently provides patients with some personal health record capability

through *MyChart*, with over 100,000 activated patient accounts. Allina maintains a vision for expanding these capabilities as well as exploring and developing web-based personal health records. These electronic personal health records could include, for example, the care contracts proposed as part of the current project, which would be “portable” should a patient relocate or change health systems. Through a sustained commitment to this type of connectivity and innovation, Allina is poised to respond auspiciously to the continuing evolution of health information technology and adapt new models of care accordingly.

**While the current proposal does not include Phases III and IV, as the proposed pilot work and Phase II are successful, we anticipate future submissions to the Robina Foundation to continue our work.**



## Closing

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At a time when many perceive the American healthcare system to be irretrievably broken, and the satisfaction of primary care physicians appears to be at its nadir, this proposal embodies a new care model designed to improve the health and quality of life for those with chronic illness and to rehabilitate the primary care environment both in terms of its efficacy for positive health outcomes and its allure for medical professionals. As described throughout this narrative, we propose to achieve this result through innovatively designed patient-centered care teams rooted in primary care clinics, and electronically shared care contracts. The ultimate aspiration is to demonstrate an economically feasible care model that activates patients and supports them in sustaining healthy behaviors, and also promotes information exchange amongst all members of a patient's core and extended care team that is comprehensive and care-enhancing. If successful, patients will be empowered to become reliable, principle agents in their own healthcare and we will have accomplished meaningful care transformation.

## Appendix A.

### Preliminary Draft of the Care Contract

#### My Promise to Take Care of My Diabetes

- ♦ I will have a care guide to work with me, free of charge (funded by a research grant).
- ♦ I will learn what national leaders call "best practice" goals for my diabetes.
- ♦ I will ask one family member or friend to be on my care team.
- ♦ My care guide, my doctor, my family member (or friend), and myself will work together to achieve "best practice" goals for diabetes.
- ♦ I agree to allow my care guide to contact my family member or friend as it relates to supporting my care.
- ♦ I will be honest and ask for help when I need it. (For example, if my medications are too expensive.)
- ♦ My care team and I will regularly review my process towards "best practice" goals.
- ♦ I agree to carry this contract with me and show it to all doctors and other care providers who treat me.
- ♦ I agree to have data about me, but not my name, studied as part of a research project on improving care.
- ♦ I can decide not to participate, or quit this program after I start, and will continue to receive care in the usual way.

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*Patient Signature & Date*

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*Care Guide Signature & Date*

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*Physician Signature & Date*

| My Progress Towards 8 "Best Practice" Diabetes Goals          |                                     |                                     |
|---------------------------------------------------------------|-------------------------------------|-------------------------------------|
|                                                               | Not Achieved<br>(0)                 | Achieved<br>(1)                     |
| Not smoking                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Using aspirin regularly                                       | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| HbA1c < 7.0% at most recent measurement                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Blood pressure < 130/80 at most recent measurement            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Funduscopy (eye) examination within the last year             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Measurement of urinary albumin excretion within the last year | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| If abnormal albuminuria, taking ACEI or ARB                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| LDL cholesterol < 100 at most recent measurement              | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| <b>Goal Total =</b>                                           |                                     | <input checked="" type="checkbox"/> |



## Appendix B.

## Budget

| Budget Category/Item                              |                         |             |           | Year 1 <sup>a</sup> | Year 2 <sup>b</sup> | Year 3 <sup>c</sup> | Total       |
|---------------------------------------------------|-------------------------|-------------|-----------|---------------------|---------------------|---------------------|-------------|
| PERSONNEL                                         | Base Salary<br>(Year 1) | %<br>Effort | #<br>FTEs |                     |                     |                     |             |
| Care Guides                                       |                         |             |           |                     |                     |                     |             |
| Pilot Phase I (ANGMA Medicine)                    | \$35,360                | 100%        | 4         | \$141,440           | \$145,683           | \$150,054           | \$437,177   |
| RCT Phase II (ANGMA COC, AMC Woodlake, AMC Edina) | \$35,360                | 100%        | 18        |                     | \$163,894           | \$675,242           | \$839,135   |
|                                                   |                         |             |           |                     |                     |                     |             |
| Project Coordinators                              |                         |             |           |                     |                     |                     |             |
| Pilot Phase I (ANGMA Medicine)                    | \$80,000                | 100%        | 1         | \$80,000            | \$82,400            | \$84,872            | \$247,272   |
| RCT Phase II (ANGMA COC, AMC Woodlake, AMC Edina) | \$80,000                | 100%        | 3         |                     | \$82,400            | \$254,616           | \$337,016   |
|                                                   |                         |             |           |                     |                     |                     |             |
| Investigators                                     |                         |             |           |                     |                     |                     |             |
| Principal Investigator: Adair                     | \$180,000               | 20%         | 1         | \$36,000            | \$37,080            | \$38,192            | \$111,272   |
| Co-Investigator: ANGMA Medicine: Lund             | \$180,000               | 5%          | 1         | \$9,000             | \$6,180             |                     | \$15,180    |
| Co-Investigator: ANGMA COC: Pierson               | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
| Co-Investigator: ANGMA COC: Post                  | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
| Co-Investigator: AMC Woodlake: TBD                | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
| Co-Investigator: AMC Woodlake: TBD                | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
| Co-Investigator: AMC Edina: TBD                   | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
| Co-Investigator: AMC Edina: TBD                   | \$180,000               | 5%          | 1         |                     | \$3,090             | \$9,548             | \$12,638    |
|                                                   |                         |             |           |                     |                     |                     |             |
| Institute for Health & Healing                    |                         |             |           |                     |                     |                     |             |
| Research Consultant: Dusek                        | \$180,000               | 5%          | 1         | \$9,000             | \$9,270             | \$9,548             | \$27,818    |
| Care Guide Training Faculty: Vitale               | \$70,000                | 15%         | 1         | \$10,500            | \$10,815            | \$11,139            | \$32,454    |
| Additional Outpatient Personnel                   | \$60,000                | 100%        | 2         |                     |                     | \$127,308           | \$127,308   |
|                                                   |                         |             |           |                     |                     |                     |             |
| Additional ANW Personnel                          |                         |             |           |                     |                     |                     |             |
| Smoking Cessation Counselor                       | \$60,000                | 100%        | 2         |                     |                     | \$127,308           | \$127,308   |
| Diabetes Educator                                 | \$60,000                | 100%        | 2         |                     |                     | \$127,308           | \$127,308   |
| Translation Services                              | \$47,840                | variable    | variable  | \$21,390            |                     | \$51,060            | \$72,450    |
|                                                   |                         |             |           |                     |                     |                     |             |
| Technical & Analytic Support                      |                         |             |           |                     |                     |                     |             |
| Clinical Decision Support                         | \$75,000                | 50%         | 1         | \$37,500            | \$12,875            |                     | \$50,375    |
| Excellian Support                                 | \$75,000                | 10%         | 1         | \$7,500             | \$7,725             | \$7,957             | \$23,182    |
| Clarity Reporting                                 | \$65,000                | 25%         | 1         | \$16,250            | \$16,738            | \$17,240            | \$50,227    |
| Data Extract, Transfer & Load Support             | \$75,000                | 5%          | 1         | \$3,750             | \$3,863             | \$3,978             | \$11,591    |
| Crystal Enterprise Support (MyEpic)               | \$75,000                | 15%         | 1         | \$11,250            | \$11,588            | \$11,935            | \$34,773    |
| Analytic                                          | \$65,000                | 25%         | 1         | \$16,250            | \$16,738            | \$17,240            | \$50,227    |
| Communications                                    | \$65,000                | 10%         | 1         | \$6,500             | \$6,695             | \$6,896             | \$20,091    |
| Research Assistant                                | \$35,360                | 100%        | 1.5       | \$53,040            | \$54,631            | \$56,270            | \$163,941   |
|                                                   |                         |             |           |                     |                     |                     |             |
| Benefits (25% of all above personnel)             |                         |             |           | \$114,843           | \$171,778           | \$458,863           | \$745,484   |
|                                                   |                         |             |           |                     |                     |                     |             |
| University of MN Advisors                         |                         |             |           |                     |                     |                     |             |
| Process Evaluation: Christianson, Wholey          |                         | 15%         |           | \$125,000           | \$128,750           | \$132,613           | \$386,363   |
| Health Economics: Town                            |                         | 5%          |           | \$14,000            | \$14,420            | \$14,853            | \$43,273    |
| Personnel Total                                   |                         |             |           | \$713,213           | \$1,002,061         | \$2,441,779         | \$4,157,053 |
|                                                   |                         |             |           |                     |                     |                     |             |
| ADDITIONAL COSTS                                  |                         |             |           |                     |                     |                     |             |
| Initial Visit Clinic Cost                         | \$112.50/visit          |             |           | \$63,000            |                     | \$668,367           | \$731,367   |
| Training Development                              |                         |             |           | \$69,000            |                     |                     | \$69,000    |
| Resource Materials Development                    |                         |             |           | \$15,000            |                     |                     | \$15,000    |
| Printing                                          |                         |             |           | \$2,800             | \$33,600            | \$56,000            | \$92,400    |
| Communications Materials                          |                         |             |           | \$7,500             | \$7,500             | \$7,500             | \$22,500    |
| Patient & Family Advisory Council                 |                         |             |           | \$4,500             | \$4,500             | \$4,500             | \$13,500    |
| Training Stipends                                 |                         |             |           | \$10,000            | \$10,000            |                     | \$20,000    |
| Food                                              |                         |             |           | \$10,000            | \$10,000            | \$10,000            | \$30,000    |
| Furniture & Equipment                             |                         |             |           | \$155,000           | \$495,000           |                     | \$650,000   |
| Research Support: IRB + SPA                       |                         |             |           | \$16,000            | \$16,000            | \$16,000            | \$48,000    |
| Home Monitoring, Computer Access                  |                         |             |           |                     |                     | \$146,250           | \$146,250   |
| Additional Costs Total                            |                         |             |           | \$352,800           | \$576,600           | \$908,617           | \$1,838,017 |

|                           |                    |
|---------------------------|--------------------|
| <b>TOTAL PROJECT COST</b> | <b>\$5,995,070</b> |
|---------------------------|--------------------|

<sup>a</sup>Year 1 = Prework phase + Pilot; <sup>b</sup>Year 2 = Pilot + RCT Prep; <sup>c</sup>Year 3 = RCT

## Budget Justification

### PERSONNEL

Each key project staff member has been previously identified in the Key Personnel section of the narrative (p.36). The budget on the previous page identifies all personnel connected with the project, their base salaries, initial percentage of effort, and the number of full time equivalents in each role. Inflation of 3% is applied to Year 2 salaries based on Year 1 and Year 3 salaries based on Year 2. Effort percentages are assigned based on level of support and input required by each staff member. Where preparation for Phase II is required, salary is budgeted for Year 2 of the project.

#### Care Guides

For Phase I, 4 care guides are included at the ANGMA-Medicine clinic. For Phase II, 18 care guides are included at the three RCT clinics (ANGMA-COC, AMC-Woodlake, AMC-Edina). Actual enrollment of patients in the RCT will dictate precise numbers of care guides. Care guide initial starting salary is \$17/hour. Note that the care guides for the RCT will be hired later in Year 2 of the project to allow for training and practice before patient enrollment.

#### Project Coordinators

For Phase I, one Project Coordinator (nurse) is included at the ANGMA-Medicine clinic. For Phase II, three Project Coordinators are included—one at each of the three RCT clinics. Project Coordinator initial starting salary is \$80,000 per year. Note that the Project Coordinators for the RCT will be hired mid-way through Year 2 of the project to allow for preparation of the RCT at each site.

#### Investigators

Dr. Dick Adair will serve as the Principal Investigator for the duration of the project, including the pre-work phase, Phase I and Phase II. He will devote 20% of his time to the project. One or two Co-Investigators (depending on the number of physicians practicing at each clinic) will also participate as part of the investigative team. Co-Investigators have been identified for the ANGMA-Medicine (one) and ANGMA-COC (two) clinics and are to be named for AMC-Woodlake (two) and AMC-Edina (two). Each of these Co-Investigators will devote 5% of their time to the project. The ANGMA-Medicine clinic Co-Investigator (Dr. Lund) is included for the pre-work and Phase I periods, while the remaining Co-Investigators are included for the Phase II pre-work and Phase II periods. All investigators have been allocated the same base salary in Year 1.

#### Institute for Health & Healing

Personnel from the Institute for Health & Healing include the Research Consultant, Dr. Dusek, who will devote 5% of his effort to this project. Ms. Vitale, one of the Care Guide Training Faculty, will be devoting 15% of her effort to this project. Finally, in anticipation of increased use of Institute for Health & Healing outpatient services during Phase II (because of the large volume of patients that are likely to be referred), two additional FTEs are included for this phase. These individuals will devote 100% of their effort to supporting patients from Phase II.

#### Additional ANW Personnel

In anticipation of increased use of smoking cessation and diabetes education services at Abbott Northwestern Hospital, two additional smoking cessation counselors and two additional diabetes

educators are included for Phase II of the project. These individuals will devote 100% of their effort to supporting patients from Phase II.

Many of the ANGMA-Medicine clinic patients are non-native English speakers. Interpretive services and translation of resources and materials into Somali and other languages will be required. Resources are determined based upon estimates that 15% of patients in the pilot phase and 5% of patients in the RCT will require interpreter services.

#### Technical & Analytic Support

A variety of technical and analytic staff will support the proposed efforts. Most significant will be personnel from the Clinical Decision Support team. Ms. Portz will lead the development and implementation of the care contract in Excellian, including managing the technical staff required during the pre-work period and Phase I. She will devote 50% of her effort to these activities during the pre-work phase and Phase I. Ongoing support of the care contract is included (i.e., Excellian Support), along with the development, creation and maintenance of cross-sectional reports required for providers and care guides to understand current patient performance, as well as trend reports allowing for reviews of performance over groups of patients and over time (i.e., Clarity Reporting, Data ETL Support, and Crystal Enterprise Support). A member of Allina's Measurement & Analysis team will provide analytic support to the investigative team, as well as the academic advisors, as necessary (i.e., Analytic). A member of the Allina communications department will support the project by facilitating internal and external communications relevant to the study (i.e., Communications). One full-time and one half-time Research Assistant are also included to provide all-purpose support to the investigative team, as well as the Project Coordinators in Phases I and II.

#### Benefits

Benefits for all above personnel are estimated at 25%.

#### University of MN Advisors

Process evaluation will be facilitated by Drs. Christianson and Wholey from the University of Minnesota's School of Public Health. Both faculty members will devote 15% of their effort for the duration of the project. Analysis of the economic impact will be conceived and directed by Dr. Town, who will devote 5% of his effort for the duration of the project. Budgeted figures include an appropriate indirect rate for the University of Minnesota.

The total personnel cost, including benefits, is \$4,157,053.

## ADDITIONAL COSTS

Again, all expenses included below are adjusted for inflation in Years 2 (3% increase over Year 1) and 3 (3% increase over Year 2).

### Initial Visit Clinic Cost

The cost of the initial clinic visit with the care guide, Project Coordinator, and patient would not be a visit typically charged to an insurer, and therefore the cost of that visit is included in the proposed project budget. Cost for the 40-minute visit is estimated at \$112.50 based on standard clinic visit charge structures. Initial visit cost for 560 patients is included for Phase I and 5,600 patients for Phase II.

### Training Development

Training expenses include the cost for extensive Excellian training for all Project Coordinators and care guides (total of 26 individuals), and limited care contract training for other providers. Training expenses additionally include the development of training modules by various faculty across Abbott Northwestern (e.g., medication affordability, resource and referral processes, message delivery and communications). It is estimated that four training modules will be developed by individuals outside of the project team, at a cost of \$7,500 per module.

### Resource Materials Development

Development of resource materials that do not already exist will be required, including content and design creation. A total of \$15,000 is devoted to supporting development of resource materials, especially those materials that cannot be developed solely by project staff.

### Printing

Materials for patients and their family members will be printed, including the resource materials noted above, as well as the care contract. Printing costs of \$15 per patient/family is included for all ANGMA-Medicine clinic and RCT clinic patients.

### Patient and Family Advisory Council

Stipends to support childcare and transportation (\$150/council member/year), as well as food for meetings (approximately quarterly), are included for the Patient and Family Advisory Council.

### Training Stipends

To cover the time of Abbott Northwestern and other personnel who will be participating in and supporting training of the care guides (e.g., diabetes educators, smoking cessation counselors, pharmacists, specialists), \$10,000 is included in training stipends during the pre-work phase (Phase I training) and Year 2 (Phase II training).

### Food

To facilitate ongoing conversations between investigators, care guides, and other project personnel, funds for food are included. These funds will be devoted specifically to supporting monthly care guide meetings, clinic staff project update meetings, investigator gatherings, and project team meetings with external personnel.

### Furniture & Equipment

Modifications to the existing ANGMA-Medicine clinic space, to accommodate the location of the care guide Help Desk area, are required. Funds are included to support new carpet (\$30,000), creation of a

computer kiosk and Help Desk area (\$25,000), as well as workstations, phones and computers for each of the care guides and the Project Coordinator (\$20,000 each). For the RCT clinics, funds are included to support the computer kiosk and Help Desk area (\$25,000 per clinic), as well as workstations, phone and computers for new staff (\$20,000 each).

Home Monitoring, Computer Access

In preparation for Phase III, approximately 75 patients enrolled in the RCT will be invited to receive a home computer for easier electronic access to health records and information (\$1500 per person). Another 75 patients enrolled in the RCT will be invited to receive home monitoring equipment to allow for more rapid clinical data feedback to providers and care guides (\$500 per person). These individuals will serve as pilot participants for aspects of Phase III that may be operationalized as we prepare for the multi-faceted intervention to improve primary care.

The total for additional costs is \$1,838,017.

**The total cost for the proposed pre-work phase, Phase I and Phase II is \$5,995,070.**

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**ROBINA FOUNDATION**

**FINANCIAL STATEMENTS**

**September 30, 2007**

**(Compiled)**

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**ACCOUNTANT'S COMPILATION REPORT**

Board of Directors  
Robina Foundation

We have compiled the accompanying statements of financial condition of Robina Foundation as of September 30, 2007, and the related statements of activities for the periods indicated and supplementary information, which is presented only for supplementary analysis purposes, as listed in the accompanying index, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of financial statements and supplementary schedules information that is the representation of the trustees. We have not audited or reviewed the accompanying financial statements and supplementary information and, accordingly, do not express an opinion or any other form of assurance on them.

Management has elected to omit substantially all of the disclosures and the statements of cash flows required by U.S. generally accepted accounting principles. If the omitted disclosures and statements of cash flows were included in the financial statements, they might influence the user's conclusions about the Foundation's financial position, results of operations, and cash flows. Accordingly, these financial statements are not designed for those who are not informed about such matters.

*Mayer Hoffman McCann P.C.*

Minneapolis, Minnesota  
November 12, 2007

**Robina Foundation**  
**COMPARATIVE STATEMENTS OF FINANCIAL CONDITION**  
**September 30, 2007**

|                                  | <u>2007</u>                 |
|----------------------------------|-----------------------------|
| <b>ASSETS</b>                    |                             |
| CURRENT ASSETS                   |                             |
| US Bank checking account         | \$ 11,201                   |
| Prepaid federal excise tax       | <u>2,691</u>                |
| TOTAL CURRENT ASSETS             | <u>13,892</u>               |
| INVESTMENTS                      |                             |
| US Bank                          | 7,032,616                   |
| TIFF Mutual Funds                | 2,554,047                   |
| Land                             | <u>1,400,000</u>            |
| TOTAL INVESTMENTS                | <u>10,986,663</u>           |
| PROPERTY AND EQUIPMENT           |                             |
| Furniture and fixtures           | 7,477                       |
| Less: accumulated depreciation   | <u>400</u>                  |
| TOTAL PROPERTY AND EQUIPMENT     | <u>7,077</u>                |
| TOTAL ASSETS                     | <u><u>\$ 11,007,632</u></u> |
| <b>LIABILITIES</b>               |                             |
| CURRENT LIABILITIES              |                             |
| Accounts payable                 | \$ 0                        |
| Accrued expenses                 | 0                           |
| Grants payable                   | <u>0</u>                    |
| TOTAL CURRENT LIABILITIES        | <u>0</u>                    |
| <b>NET ASSETS</b>                |                             |
| Foundation equity                | <u>11,007,632</u>           |
| TOTAL NET ASSETS                 | <u>11,007,632</u>           |
| TOTAL LIABILITIES AND NET ASSETS | <u><u>\$ 11,007,632</u></u> |

See Accountants' Compilation Report



**Robina Foundation**  
**COMPARATIVE STATEMENTS OF ACTIVITIES**  
 Nine Months Ended September 30, 2007

|                                              | <u>Current Quarter This Year</u> |              | <u>Year-To-Date This Year</u> |              |
|----------------------------------------------|----------------------------------|--------------|-------------------------------|--------------|
|                                              | <u>Amount</u>                    | <u>%</u>     | <u>Amount</u>                 | <u>%</u>     |
| <b>REVENUES</b>                              |                                  |              |                               |              |
| Investment income:                           |                                  |              |                               |              |
| Interest income                              | \$ 87,178                        | 65.2%        | \$ 306,718                    | 85.0%        |
| Dividend income                              | 20,657                           | 15.5         | 40,750                        | 11.3         |
| Capital gain distributions                   | 25,796                           | 19.3         | 25,796                        | 7.2          |
| Realized gains and losses                    | 0                                | 0.0          | 0                             | 0.0          |
| Investment fees                              | 0                                | 0.0          | (12,500)                      | 3.5          |
| Total investment income                      | 133,631                          | 100.0        | 360,764                       | 100.0        |
| Contributions                                | 0                                | 0.0          | 0                             | 0.0          |
| Miscellaneous income                         | 0                                | 0.0          | 0                             | 0.0          |
| <b>TOTAL REVENUES</b>                        | <b>133,631</b>                   | <b>100.0</b> | <b>360,764</b>                | <b>100.0</b> |
| <b>EXPENSES</b>                              |                                  |              |                               |              |
| Grants paid                                  | 0                                | 0.0          | 0                             | 0.0          |
| Administrative expenses                      | 126,200                          | 94.4         | 355,033                       | 98.4         |
| <b>TOTAL EXPENSES</b>                        | <b>126,200</b>                   | <b>94.4</b>  | <b>355,033</b>                | <b>98.4</b>  |
| <b>OPERATING INCOME (LOSS)</b>               | <b>7,431</b>                     | <b>5.6</b>   | <b>5,731</b>                  | <b>1.6</b>   |
| Federal excise tax                           | 0                                | 0.0          | 4,600                         | (1.3)        |
| <b>INCREASE (DECREASE) IN<br/>NET ASSETS</b> | <b>\$ 7,431</b>                  | <b>5.6%</b>  | <b>1,131</b>                  | <b>0.3%</b>  |
| <b>NET ASSETS, BEGINNING OF YEAR</b>         |                                  |              | <b>11,006,501</b>             |              |
| <b>TOTAL NET ASSETS</b>                      |                                  |              | <b>\$ 11,007,632</b>          |              |

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# Robina Foundation

## SCHEDULES OF ADMINISTRATIVE EXPENSES

Nine Months Ended September 30, 2007

|                                      | <u>Current Quarter This Year</u> |             |                | <u>Year-To-Date This Year</u> |             |                | <u>Variance</u> |
|--------------------------------------|----------------------------------|-------------|----------------|-------------------------------|-------------|----------------|-----------------|
|                                      | <u>Actual</u>                    | <u>%</u>    | <u>Budget</u>  | <u>Actual</u>                 | <u>%</u>    | <u>Budget</u>  |                 |
| <b>ADMINISTRATIVE EXPENSES:</b>      |                                  |             |                |                               |             |                |                 |
| Accounting & audit fees              | \$ 8,900                         | 6.7         | \$ 3,750       | \$ 10,725                     | 3.0         | \$ 11,250      | \$ 525          |
| Bank charges                         | 0                                | 0.0         | 250            | 213                           | 0.1         | 750            | 537             |
| Contract services:                   |                                  |             |                |                               |             |                |                 |
| Gordon Aamoth                        | 43,752                           | 32.7        | 43,750         | 116,672                       | 32.3        | 131,250        | 14,578          |
| Jean Sazevich                        | 12,500                           | 9.4         | 12,500         | 26,375                        | 7.3         | 25,000         | (1,375)         |
| Nancy Gilbert                        | 0                                | 0.0         | 0              | 740                           | 0.2         | 740            | 0               |
| Baker Management                     | 5,700                            | 4.3         | 5,700          | 9,450                         | 2.6         | 9,450          | 0               |
| Tim Harrison - Robina                |                                  |             |                |                               |             |                |                 |
| Land Maintenance                     | 12,500                           | 9.4         | 7,500          | 12,500                        | 3.5         | 22,500         | 10,000          |
| Other consultants                    | 11,568                           | 8.7         | 3,750          | 11,825                        | 3.3         | 11,250         | (575)           |
| Depreciation expense                 | 400                              | 0.3         | 400            | 400                           | 0.1         | 400            | 0               |
| Directors' fees                      | 0                                | 0.0         | 10,000         | 0                             | 0.0         | 30,000         | 30,000          |
| Insurance:                           |                                  |             |                |                               |             |                |                 |
| Directors' and officers              | 0                                | 0.0         | 1,200          | 4,800                         | 1.3         | 3,600          | (1,200)         |
| Property                             | 0                                | 0.0         | 450            | 1,782                         | 0.5         | 1,350          | (432)           |
| Legal fees                           | 19,959                           | 14.9        | 50,000         | 129,608                       | 35.9        | 150,000        | 20,392          |
| Meeting expense                      | 2,458                            | 1.8         | 5,000          | 13,794                        | 3.8         | 15,000         | 1,206           |
| Membership dues                      | 1,852                            | 1.4         | 241            | 2,817                         | 0.8         | 724            | (2,093)         |
| Miscellaneous expense                | 129                              | 0.1         | 250            | 165                           | 0.0         | 750            | 585             |
| Office expense                       | 0                                | 0.0         | 125            | 8                             | 0.0         | 375            | 367             |
| Office supplies                      | 404                              | 0.3         | 250            | 690                           | 0.2         | 750            | 60              |
| Parking & mileage                    | 376                              | 0.3         | 125            | 505                           | 0.1         | 375            | (130)           |
| Postage & delivery                   | 277                              | 0.2         | 75             | 332                           | 0.1         | 225            | (107)           |
| Printing, web design & maintenance   | 1,113                            | 0.8         | 2,000          | 1,158                         | 0.3         | 6,000          | 4,842           |
| Professional development             | 650                              | 0.5         | 1,250          | 2,447                         | 0.7         | 3,750          | 1,303           |
| Property taxes                       | 1,052                            | 0.8         | 550            | 2,111                         | 0.6         | 1,650          | (461)           |
| Publications & subscriptions         | 0                                | 0.0         | 125            | 0                             | 0.0         | 375            | 375             |
| Rent expense                         | 1,870                            | 1.4         | 1,890          | 3,740                         | 1.0         | 3,780          | 40              |
| Telephone & internet                 | 740                              | 0.6         | 800            | 2,176                         | 0.6         | 2,400          | 224             |
| <b>TOTAL ADMINISTRATIVE EXPENSES</b> | <u>126,200</u>                   | <u>94.4</u> | <u>151,931</u> | <u>355,033</u>                | <u>98.4</u> | <u>433,694</u> | <u>78,661</u>   |

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