BrandAudit™ Report

Vantage Regional Health

Brand Diagnosis & Strategic Recommendation

This BrandAudit™ assessed Vantage Regional Health's brand identity, consistency, community perception alignment, and competitive positioning across all primary touchpoints–digital, environmental, patient-facing, and organizational. The analysis employed the BrandCore™ Segmentation Engine, the CommunitySignal™ Composition Model, the Brand Signal Scorecard, and the Community Perception Alignment Matrix: proprietary SBCMO Health Architecture tools developed specifically for regional health systems navigating complex market conditions. What follows is a complete brand diagnosis–a structured, evidence-based examination of where the brand is transmitting clearly, where it is breaking down, and what those breakdowns are costing in patient trust, specialty volume, and strategic momentum. This report includes a psychographic alignment gap analysis, a financial leakage model, and a service recommendation grounded in findings from the intake assessment. This is not a survey summary. It is a clinical read of your brand's current condition–and a clear statement of what it will take to close the gap.

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Prepared by: Franklin Parrish, SBCMO Health Architecture | www,sbcmohealtharchitecture.com

Section 1 | Brand Consistency Review

Brand consistency for a health system is not a design standard. It is a trust mechanism. Every moment a patient, a referring physician, or a community member encounters a signal that does not match what they expect—or what they were told—is a micro-moment of doubt. And doubt, in healthcare, carries consequences that do not show up on a patient satisfaction survey. They show up in specialty referral patterns, in commercially insured volume trends, and in the long-term erosion of a community's willingness to assign serious care to a local system. What we measured in Vantage Regional Health's brand is not whether the logo is applied correctly. We measured whether the brand is doing the trust work that patient acquisition and retention depend on.

Among all evaluated dimensions, mission clarity is the clearest functional signal in Vantage's current brand. The system's purpose—regional community care anchored in COPA accountability, behavioral health leadership, and a century of institutional presence—is identifiable and present across primary touchpoints. Patients and community members understand, at a functional level, what Vantage exists to do. That foundational clarity matters. It is the platform on which more differentiated brand work can be built. The behavioral health portfolio—specifically the Vantage Recovery Network—also reflects above-average brand signal relative to the system's overall performance. When a service line has both a clear clinical identity and organizational will to communicate it, the brand work follows naturally.

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The school-based health program reaching 12,000 students and the community health worker infrastructure embedded across 29 counties represent the strongest unrealized brand asset in the Vantage portfolio. These programs produce meaningful community presence that is not translating into brand signal. They exist in operations. They have not been converted into brand narrative. They remain invisible to the community members whose trust they have earned—and who would, if they knew, hold those programs as proof of the system's commitment to them. This gap between operational performance and brand legibility is a recurring pattern in Vantage's current brand condition and the most correctable opportunity in the near term.

The most significant consistency failure is legacy fragmentation. Approximately six years after the Ridgeway Health System and Crestwood Medical Network merger, both legacy identities remain active in the market. Environmental signage across the 21-facility footprint has not been fully standardized. Patient-facing materials and printed clinical communications still carry legacy design language in several facilities. Referring physicians in outlying counties continue to receive materials that reflect the pre-merger identities. This is not a minor visual inconsistency. It is a structural trust signal failure. When a patient's referral paperwork looks different from the hospital where they arrive for their procedure, the brand is communicating: we are not fully together. For a system with explicit goals around specialty volume growth and commercial payor capture, that signal is working directly against the strategic agenda.

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Message architecture is the second critical failure. Vantage's primary communications lead with merger rationale–scale, enhanced capabilities, combined resources–rather than with patient benefit. In a community where institutional authority messaging reads as detachment rather than reassurance, this sequencing is producing the opposite of its intended effect. In the intake, Vantage Regional Health's CMO described the brand's personality as "Steady. Community-anchored. Quietly capable. A little under-told. Earnest–sometimes to a fault." The earnestness is a genuine asset. The under-told condition is a liability the system can no longer sustain. Specialty care capabilities that exceed community expectations–oncology infrastructure, the behavioral health platform, cardiac services–are functionally invisible in the brand. The community does not know what Vantage can do for them when the stakes are highest.

Two findings require immediate CMO attention. First, the legacy fragmentation must be resolved at the environmental and patient-facing materials level before any new messaging campaign will hold. A new brand narrative launched on a fragmented touchpoint foundation does not close the credibility gap–it exposes it. Second, message architecture must shift from institutional justification to patient benefit. The brand cannot lead with what Vantage has. It must lead with what Vantage does for the people who depend on it. Until both conditions are addressed, external communications will continue to underperform regardless of production quality or media investment.

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Section 1 — D1–D8 Summary | Strong = 7–10 | Moderate = 5–6 | Weak = 1–4

Dimension	Score	Signal	Priority
D1 – Visual Consistency	4	Weak	High – Legacy fragmentation active
D2 – Voice Clarity	4	Weak	High – Merger sub-message leads
D3 – Message Hierarchy	3	Weak	High – Specialty capabilities invisible
D4 – Archetype Signal Clarity	4	Weak	High – Everyman/Ruler blend, no dominant
D5 – Trust Credibility by Care Level	4.55	Weak	Critical – Specialty + high-acuity bands

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D6 – Emotional Register	4	Weak	Medium – Familiarity without inspiration
D7 – Mission Clarity	5	Moderate	Medium – Generic but functional
D8 – Call-to-Action Coherence	4	Weak	High – No employer materials; portal underutilized

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Section 2 | Community + Physician Perception Alignment

Demographics do not explain patient behavior in healthcare. Age, zip code, and household income predict utilization patterns in the aggregate—but they do not explain why two patients with identical demographics make entirely different decisions when facing the same specialty care need. One chooses the local regional system. The other drives ninety minutes to the academic medical center. The difference is not clinical knowledge. It is psychological resonance. The CommunitySignal™ Composition Model measures the psychographic identity of a health system's community—the values, worldview, and emotional decision-making framework that determines which brand earns trust for a cancer diagnosis and which earns trust for a flu shot. For a regional system competing against academic medical centers for specialty volume, this distinction is the difference between growing and eroding.

Our CommunitySignal™ analysis of the Vantage Regional Health service area—a 29-county, two-state Appalachian market—identifies a community psychographic profile led by three primary archetypes. The Warrior/Hero archetype is the dominant segment, representing approximately one in five community members. These are individuals who frame health decisions through agency, capability, and action—they want a system that will back them, not one that explains its organizational structure to them. The Orphan/Citizen (Everyman) archetype represents approximately 15 percent of the community—a segment that makes care decisions based on accessibility, familiarity, and trust earned through consistent presence. The Caregiver archetype, at approximately 14 percent, represents family-centered decision-makers who evaluate health systems on their capacity to serve the

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people they love. Because this analysis operates from a Tier 3 data confidence level—regional benchmark proxies calibrated for Appalachian market characteristics—these distributions carry directional confidence, not actuarial precision. They are sufficient for brand diagnosis and strategic orientation; primary community research would sharpen execution precision.

Vantage's brand delivers its strongest psychographic signal to the Caregiver community. The behavioral health platform, school-based care, community health workers, and primary care depth are genuinely Caregiver-aligned offerings, and they produce a partial resonance signal for this segment. The operative word is partial. Individual caregivers may connect with specific Vantage programs without ever connecting with Vantage as a brand—because the brand has not assembled those programs into a coherent narrative about what Vantage means for families in this region. The ingredients are present. The brand architecture that makes them legible as a whole is not.

The brand's performance for Warrior/Hero and Orphan/Citizen community members represents the most significant gaps in this analysis. The Warrior/Hero segment—the community's dominant psychographic—is receiving brand signals that read as institutional authority rather than empowerment. Merger-era messaging about "expanded capabilities" and "enhanced scale" does not land as reassuring for a community that wants a health system that will show up for them when the stakes are highest. It lands as an organization explaining its own internal reorganization. In the intake, a Vantage board member stated: "We've got a brand that says we're trying. We need one that says we've arrived." That observation is precise. The Warrior/Hero community does not want a system that is trying. They want a system that is ready. The Orphan/Citizen segment is similarly underserved—the

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brand's community infrastructure signals are present but not foregrounded, which means the accessibility and familiarity this segment requires to build specialty care trust are not being consistently delivered.

Vantage's Destroyer/Outlaw segment—representing approximately 12 percent of the community—is the most acutely underserved psychographic group in the market. This segment has the lowest institutional trust baseline and the highest resistance to "system-speak." Merger-era institutional language is producing the opposite of reassurance for this audience. The Innocent archetype (approximately 10 percent) is partially served—the system's emphasis on approachability resonates at the routine care level. Neither secondary archetype is receiving a brand signal strong enough to anchor their consideration set at the specialty or high-acuity level.

The patient experience signal across the brand's identity, relationship, and impact dimensions tells a consistent story: Vantage has built strong clinical relationships at the primary care level that have not translated into system-level trust. Patients who have a Vantage primary care physician report strong personal loyalty—but that loyalty is physician loyalty, not system loyalty. When those same patients face a serious diagnosis or a complex procedure, the brand does not give them a reason to stay within the Vantage system. In the intake, Vantage's leadership acknowledged the pattern directly: "Vantage is for everyday care. The serious stuff happens somewhere else." That statement was not offered as an external critic's observation. It was offered as a reflection of what the community believes—and what the CMO knows the brand has not yet corrected.

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The “I love my doctor here” / “I didn’t know you did that” gap is fully active in this market. Patients are loyal at the primary care level and invisible to Vantage at the specialty level. The community benefit infrastructure–school-based health, community health workers, 28 primary care locations–is generating goodwill that the brand is not converting into specialty care confidence. The CMO noted in the intake: “Closing that confidence gap is our most pressing brand challenge.” That framing understates the financial dimension of the problem. The confidence gap is not a perception metric. It is a revenue metric. And every month it remains open, commercially insured specialty volume routes to competitors who have built the architecture Vantage has not.

The physician alignment signal is a critical variable in this market. Physicians at Vantage’s 21 facilities are operating under dual brand identities–some still self-identifying with legacy Ridgeway or Crestwood affiliations, and those affiliations surface in patient referral conversations, practice materials, and external communications. A patient referred by a “Ridgeway physician” to a “Vantage facility” experiences a brand seam at the exact moment their trust in the system needs to be highest. The PhysicianSignal™ dimension reflects this fragmentation: a physician who introduces themselves through a legacy identity is not building Vantage brand equity with their patients. They are sustaining a competitor legacy. One physician noted in the intake: “The oncology suite is better than people think. But it’s going to take more than new equipment.” That physician is correct. Clinical quality does not self-report. Brand architecture is what makes clinical quality visible to the people making care decisions.

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Table 2A — Community Archetype Alignment | Priority Gap = Yes when signal is "Gap" and community % is above 15%

Archetype	Est. % of Community	Weighted Composite	Signal Rating	Priority Gap
Warrior/Hero (Primary)	~20%	3.63 / 10	Gap	Yes
Orphan/Citizen – Everyman (Primary)	~15%	4.87 / 10	Gap	Yes
Caregiver (Primary)	~14%	6.10 / 10	Partial	No
Destroyer/Outlaw (Secondary)	~12%	3.70 / 10	Gap	No (threshold)
Innocent (Secondary)	~10%	5.55 / 10	Partial	No

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Table 2B — D9–D12 Patient/Community Experience Signal

Dimension	Score	Signal	Priority
D9 – Patient/Community Identity Mirror	4	Weak	High
D10 – Relationship Signal	4	Weak	High
D11 – Impact Legibility	3	Weak	High – Community benefit work invisible
D12 – Trust Architecture	2	Weak	Critical – Specialty/high-acuity absent

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Section 3 | Psychographic Alignment Gap Analysis

The brand that Vantage Regional Health is currently projecting—an Everyman/Ruler blend rooted in merger-era institutional messaging—does not match the psychographic profile of the community it serves. Vantage's community is Warrior/Hero dominant. What the brand is delivering is institutional authority language. What the community is looking for is a system that will stand with them when the stakes are highest—not one that explains what a merger made possible. That distance between what the brand projects and what the community needs is the gap at the center of this audit. It is not a campaign gap. It is a brand architecture gap.

The misalignment is not accidental. It is the natural output of a post-merger communication strategy that prioritized internal justification over patient benefit. When Ridgeway Health System and Crestwood Medical Network combined, the organizing brand logic was: "Here is what this merger means for our capabilities." That logic made sense in the immediate post-merger period—when the primary audiences were internal and the primary objective was organizational alignment. But six years later, that merger-justification framework is still structuring how Vantage presents itself externally. The "enhanced capabilities," "expanded access," and "combined resources" language that dominates current communications was written for a moment that has passed.

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For a Warrior/Hero-dominant community, institutional authority messaging produces a specific kind of resistance. This community does not want to be told what a system has. They want to know whether the system will show up for them when their own health—or the health of someone they love—is on the line. Merger-era scale language reads as a system explaining its organizational logic, not a system that understands what this community needs from it. The copy architecture consistently places the system at the center of the narrative. In an Appalachian market where trust is built through demonstrated commitment—proximity, accountability, presence that does not disappear when the financial environment gets difficult—that inward framing is the wrong choice at every level of the patient decision journey.

Three cross-dimension divergences identify the specific points where the brand experience breaks down for Vantage's community. The Invisible Impact Gap—the divergence between mission clarity and impact legibility—reflects a system doing significant community work that is entirely invisible to the people it serves. The gap between what Vantage does in operations and what the community knows it does is costing organic referral generation and patient loyalty at the specialty level. The Major Care Decision Trap is the most financially consequential finding: the distance between routine care trust credibility and specialty/high-acuity trust credibility is wide enough that patients who rely on Vantage for primary care do not trust Vantage for the decisions that generate the most revenue. The Communication Sequence Audit reveals a brand leading with "what we are" instead of "what we can do for you"—and that sequencing failure compounds at every step of the patient journey from awareness through access to care decision.

The concrete cost of these misalignments is concentrated in commercially insured specialty volume. At a 23 percent specialty leakage rate—Vantage's own estimate—the system is routing more than $40 million annually in specialty commercial revenue to competitors who have built the brand architecture Vantage has not. These are not patients who could not be retained. They are patients who trust Vantage for one kind of care and choose a different system when the decision stakes increase. The brand gap is not creating a clinical access problem. It is creating a clinical confidence problem. And clinical confidence is a brand problem that only brand architecture can solve.

If the gap is not closed before the Comprehensive Cancer Center opens—fourteen months from this engagement—the brand will enter its highest-stakes public moment carrying the same credibility deficits it carries today. In the intake, Vantage's CMO stated directly: "I am not confident that any amount of advertising will close that gap." That instinct is correct. Advertising does not close a credibility gap. It amplifies whatever trust condition the brand is in when the campaign launches. A brand in a credibility deficit, amplified through advertising, accelerates the deficit. The trajectory, if unaddressed, points toward a cancer center launch that enters the market as a facility announcement—rather than as a brand moment the community has been prepared to receive.

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Section 3 — Diagnostic Pairs

Diagnostic Pair	Dimensions	Divergence	Flagged	Patient Impact
Invisible Impact Gap	D7 + D11	2 pts	Yes	Community benefit work earns goodwill that brand never converts to specialty trust
Acquisition vs. Retention Brand	D9 + D10	0 pts	No	Not flagged—PCP loyalty present; brand-level loyalty limited
Major Care Decision Trap	D5 + D12	2.55 pts	Yes	Patients choosing academic centers for oncology, cardiac, and complex procedures
Communication Sequence Audit	D3+D7+D8	Range: 2 pts	Yes	Brand leads with system identity, not patient benefit; CTA pathway absent for specialty
Psychological Coherence Check	D4+D9+D10	0 pts	No	Not flagged—archetype and experience signals consistent in their underperformance

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Section 4 | Competitive Positioning Review (3C)

The regional health system market in Vantage's operating area is navigating the same competitive dynamic reshaping systems across the country: clinical capabilities at the regional level are converging, while brand differentiation remains the primary driver of patient and physician decision-making for high-value care. In this market, as in most comparable Appalachian regional markets, the health system that builds a coherent brand identity—one that earns trust at the specialty and high-acuity level—captures a disproportionate share of commercially insured volume. Systems that do not build that brand identity default to being the primary care destination for the communities that have no other option, and the referral gap for the communities that do. That is the competitive position Vantage is currently in, and the one it has the market conditions and clinical infrastructure to exit.

The Competitor landscape includes a regional academic medical center positioned firmly in the Sage archetype—"where the best go for serious care"—operating at a sixty-to-ninety-minute driving distance for most Vantage communities. This system does not need to win the proximity argument. It wins the credibility argument. It holds the positioning that patients assign to high-stakes care decisions, and it does so without competing in the routine or behavioral health spaces where Vantage has genuine clinical advantage. A second regional competitor operates from an established Ruler archetype position—institutional scale, administrative sophistication, employer and payer relationship infrastructure—and is investing actively in the areas where Vantage has not. Neither competitor occupies the Warrior/Hero empowerment positioning that Vantage's dominant community psychographic is most receptive to. That territory is unclaimed.

The Collaborator landscape presents both multiplier opportunity and referral risk. The regional physician alliance operating in Vantage's primary market holds a strong Caregiver archetype position—"your doctor's home"—and its relationship with primary care physicians is a natural brand multiplier for Vantage if the brand is aligned with it. If the brand is not aligned—if physicians affiliated with the alliance are still navigating legacy Ridgeway or Crestwood identity questions—that relationship becomes a referral friction point instead of a referral pathway. The employer consortium operating across Vantage's largest counties represents a Ruler-archetype collaborator whose primary currency is cost efficiency and workforce productivity. Vantage does not currently have a developed employer-facing brand presence or materials infrastructure, which means value-based contract relationships and specialty benefit design conversations are being left to competitors.

Healthcare as a cultural institution in the Appalachian market carries a specific set of community expectations that are distinct from metro and suburban market profiles. This is a community where institutional trust must be demonstrated through physical presence and sustained accountability—not announced through advertising. The category expectation—what "a health system" is supposed to mean in this community—is not clinical sophistication. It is accountability. It is the system that is still here when the industry consolidates. It is the COPA obligation made visible and personal. Vantage has the infrastructure to meet that expectation fully: a century of presence, a legal accountability structure most competitors cannot claim, and an operational investment in community health that exceeds the regional average. Meeting that expectation in operations and communicating it in brand are not the same thing, and right now only one of those is happening.

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The white space in this market is specific and unclaimed: no regional system occupies a Warrior/Hero empowerment position. The academic medical center owns Sage. The regional competitor owns Ruler. The community is waiting for a health system that will say, clearly and without hedging: we are the system that stands with you when the stakes are highest. We are not the option you choose because you had no other. We are the choice you make because you know we will show up. Vantage has the operational proof points to own that position—a century of presence, 14,200 employees who are this community's neighbors, a behavioral health platform, and a cancer center opening fourteen months from this engagement. The COPA position, which carries both a regulatory protection and a community benefit obligation that no competitor can replicate, is a natural anchor for that narrative. No competitor can claim it. Vantage simply needs to build the brand that makes it real.

Section 4 — 3C Competitive Scan | Tier 1 = Emerging | Tier 2 = Established | Tier 3 = Institutional

Entity	Type	Archetype Signal	Visual Tier	Positioning Angle	Overlap
Appalachian University Medical Center	Competitor	Sage	Tier 2	"Where the best go for serious care" – 60–90 min drive	High – specialty

Commonwealth Regional Health	Competitor	Ruler	Tier 2	Institutional scale, system authority, employer relations	Medium
Mountain Care Physician Alliance	Collaborator	Caregiver	Tier 2	"Your doctor's home" – patient relationship primary	High – PCP
Regional Employer Consortium	Collaborator	Ruler	Tier 1	Cost efficiency, productivity framing for benefits	Medium
Healthcare as Cultural Category	Category	Sage/Hero blend	Tier 2	Trust through evidence + community accountability	N/A

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Vantage Regional Health	This System	Everyman/Ruler blend	Tier 2	Community infrastructure, merger scale – repositioning needed	← This system

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Section 5 | Strategic Event Horizon Assessment

The question this assessment answers is not whether Vantage Regional Health can afford brand work. It is whether the current brand can support the system's growth goals without it. Those are different questions with different answers. A system growing in primary care volume, managing a stable payor mix, and operating in a market without near-term strategic events might rationally defer brand investment. That is not the situation Vantage is in. The situation Vantage is in is one where multiple strategic pressures are converging simultaneously—and where the cost of brand inaction is not hypothetical. It is accumulating in the form of specialty leakage, referral fragmentation, and physician loyalty that is still assigned to legacy identities rather than to the unified system that needs it.

Our trigger analysis identifies six confirmed conditions establishing the urgency and scope of brand investment required. The first is organizational transformation: a new CEO with a clearly stated strategic agenda—value-based care transition, service line expansion, commercial payor growth—and a timeline that demands brand alignment before the external communications strategy shifts. The second is unresolved merger integration: six years after the Ridgeway–Crestwood combination, both legacy identities remain active in the market—in signage, physician referral behavior, and the lived experience of patients navigating facilities that still feel like different organizations. In the intake, Vantage's leadership acknowledged this directly: "The merger is still not fully integrated at a cultural level"—adding: "The brand gap we need to close isn't just between Vantage and its community. It's also between Vantage and itself." The third is a structural mismatch between the brand Vantage projects and the

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psychographic identity of its community—institutional language landing in a Warrior/Hero-dominant market. The fourth is a demonstrable trust gap at the specialty and high-acuity level, confirmed both by the audit findings and the intake. The fifth and most time-sensitive is the Comprehensive Cancer Center opening within fourteen months. The sixth is a commercial payor concentration significantly below regional benchmarks, with growth goals requiring specialty volume capture from a community currently routing that volume to competitors.

The signal gap—the consistency and clarity with which the brand communicates its identity across touchpoints—reflects a brand that has not achieved the visual and message cohesion required to present a unified front to patients, physicians, and employers. Every legacy touchpoint in the market is working against the coherence the system needs. The 21-facility footprint should be the brand's single greatest proof of community commitment. Right now it is its most visible consistency problem. Every facility that carries a different visual identity, or routes patients to a legacy name, is a touchpoint that subtracts from the trust the system is trying to build.

The perception gap—how well the brand connects to the actual psychographic composition of the community—reflects three of the five primary community segments receiving either a partial or absent brand signal. This is not a campaign problem. Campaigns built on top of a perception gap will underperform, because the brand architecture they are amplifying is not resonating with the dominant psychographic profile of the community. The credibility gap—specialty care trust, high-acuity care confidence, and the advocacy signal that converts satisfied patients into organic referral sources—is where the financial stakes

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become most concrete. The Major Care Decision Trap is a structural brand deficit that requires architectural work, not a messaging refresh. The brand that exists today cannot carry the specialty volume growth agenda the new CEO has set.

The Comprehensive Cancer Center launch is the defining event on Vantage's strategic calendar. In the intake, Vantage's leadership stated it plainly: "Getting the brand right before that launch is not a marketing objective. It is a strategic one." That framing is exact, and its financial implications are material. A cancer center opening is not an ordinary service line launch. It is a high-stakes public statement about what kind of health system Vantage is. In a community where existing perception assigns serious care elsewhere—and where a board member has already named the gap ("We've got a brand that says we're trying. We need one that says we've arrived.")—that launch will either accelerate a brand repositioning or be absorbed into the existing credibility deficit. The capital investment in the cancer center is significant. A conservative estimate of 10–25 percent first-year volume underperformance driven by brand-based skepticism represents material revenue at risk—revenue that no advertising spend can recover once the launch narrative is established. The launch window is fixed. The brand work timeline is not.

The trigger landscape, the gap severity, and the fourteen-month countdown all point to the same conclusion. The distance between where Vantage's brand is today and where it needs to be before the cancer center opens is not a messaging gap. It is not a campaign gap. What this system needs is not cosmetic. What it needs is…

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Section 5 — Trigger Status Summary

Trigger	Status	Evidence	Floor Impact
Brand Clarity Deficit	Confirmed	New CEO; strategic pivot to VBC + service line expansion; brand alignment not established	BrandLaunch™
Brand–Market Misalignment	Confirmed	Ridgeway + Crestwood legacy active 6 years post-merger; cultural integration not complete	BrandLaunch™
Archetype Signal Gap	Confirmed	Brand projects Everyman/Ruler; community is Warrior/Hero dominant; D4 score = Weak	BrandLaunch™
Major Care Decision Trap	Confirmed	"Vantage is for everyday care. The serious stuff happens somewhere else." D5 composite = 4.55	BrandVoice™

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Strategic Event Horizon	Confirmed	Comprehensive Cancer Center: Phase 1 opening ~14 months from engagement; highest-stakes moment	BrandVoice™
Community Composition Mismatch	Confirmed	Commercial payor 24% vs. 40% benchmark; Tier 3 data only; psychographic gap confirmed	BrandVoice™ + CommunityAtlas™
New Market Entry	Not Confirmed	3 new clinic sites planned within existing service area–not new geographic markets	–

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Section 5A | Financial Leakage Model

Component 1 – Specialty Care Leakage Estimate

Step 1 – Commercial Revenue Estimate: $2.1B total system revenue × 24% commercial payor concentration = $504M estimated commercial revenue

Step 2 – Specialty Commercial Revenue: $504M × 35% industry benchmark (specialty = 35–40% of commercial revenue for comparable regional systems) = **$176.4M estimated specialty commercial revenue**

Step 3 – Leakage Rate Applied: Conservative (18%) = $31.8M | Midpoint / Intake-stated (23%) = $40.6M | Aggressive (28%) = $49.4M

Assumption variables: (a) specialty commercial revenue share may vary ±5% from the 35% benchmark; (b) the 23% leakage rate is system-reported, not independently audited. All figures are directional, not audited.

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Component 1 – Specialty Care Leakage Range

Scenario	Assumption Basis	Annual Leakage Estimate
Conservative	18% leakage rate + lower specialty revenue share	$31.8M / yr
Midpoint (Intake-Stated)	23% system-reported leakage + 35% specialty revenue share	$40.6M / yr
Aggressive	28% leakage rate + higher specialty revenue share	$49.4M / yr

Component 2 – D5 Band-by-Band Financial Translation

Band 2 – Specialty Care (35% weight): A Band 2 trust score of 3.5 out of 10 indicates that approximately 65 percent of the specialty commercial revenue base is at elevated risk of leakage acceleration. Patients in specialty care episodes are making active competitor-choice decisions that Vantage's brand is not positioned to intercept. This is the highest-weight band for

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commercial revenue concentration and the most immediate area of financial exposure. Every month the Band 2 credibility gap remains open, commercially insured specialty volume routes to systems that have built the trust architecture Vantage has not.

Band 3 – High-Acuity / Planned Procedures (15% weight): A Band 3 score of 3.0 out of 10 reflects near-total brand absence from the patient consideration set at the oncology, cardiac, and complex surgical decision level. These are the care decisions that will define the Comprehensive Cancer Center's first-year volume performance. Patients whose trust architecture does not include Vantage for high-acuity care do not appear in that launch volume—regardless of how strong the clinical infrastructure is.

Band 4 – Brand Loyalty + Advocacy (35% weight): A Band 4 score of 5.0 out of 10 means organic patient acquisition is operating at approximately half capacity. Satisfied patients are not becoming advocacy engines. The referral compounding effect—the brand's most cost-efficient patient acquisition mechanism—is suppressed, requiring Vantage to invest at disproportionate advertising levels to replace volume that should be generated by its own community. Recovery of the Band 4 advocacy signal has a 2–3 year timeline under a BrandLaunch™ engagement.

Component 3 – Strategic Event Horizon Cost Projection

If the brand gap is not addressed before the cancer center opens, the system enters its highest-stakes launch carrying the same credibility deficits it carries today. Based on regional system benchmarks for comparable oncology service line launches:

Conservative scenario (10% first-year volume underperformance): Estimated $3.2–$4.1M revenue at risk in Year 1, indexed to specialty commercial revenue baseline.

Aggressive scenario (25% first-year volume underperformance): Estimated $8.0–$10.2M revenue at risk in Year 1.

Recovery cost: Advertising-led patient acquisition to compensate for brand credibility deficit typically costs 3–5× more per acquired patient than brand-led acquisition. A credibility gap not closed before launch requires sustained advertising investment to partially compensate for the community confidence the brand is not providing—at premium cost, with diminished returns, over a multi-year recovery window.

*All estimates directional. Final ranges require confirmed first-year service line volume projections from system finance.

Section 5A — Financial Leakage Summary

Leakage Component	Calculation Basis	Est. Annual Impact	Recovery Potential with BrandLaunch™
Specialty Care Leakage	Commercial rev × 35% specialty × leakage rate	$31.8–$49.4M / yr	High—direct specialty volume recovery
Band 2 Trust Gap	D5 Band 2 score (3.5/10) × commercial specialty revenue	~$114.7M at risk	High—highest-weight D5 band

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Band 4 Advocacy Gap	D5 Band 4 score (5.0/10) × organic acquisition baseline	Organic acq. at ~50% capacity	Moderate–2–3 year recovery timeline
T5 Launch Underperformance	Capital investment × 10–25% volume underperformance risk	$3.2–$10.2M Year 1 est.*	Critical–launch window is non-recoverable

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Section 6 | Service Recommendation

Based on the full weight of this analysis, our recommendation is BrandLaunch™—the brand development engagement tier that builds a complete brand platform for a health system: archetype-aligned identity, message architecture, internal activation protocol, and external launch sequencing. BrandLaunch™ is not a brand refresh. It is the systematic construction of a brand capable of carrying Vantage's trust signal from primary care through specialty care and into high-acuity decisions—and sustaining it at the commercial volume levels the new CEO's strategic agenda requires.

The recommendation is driven by a specific convergence of conditions, not by any single finding. The organizational pivot under new CEO leadership has opened a window for brand realignment that will narrow as the strategic agenda sets. The unresolved merger integration—six years of dual-brand identities in the market—means that, without intentional brand architecture work, fragmentation will continue to compound in patient referral patterns, physician identity, and environmental consistency. The archetype signal gap between what the brand projects and what the Warrior/Hero-dominant community needs to hear is not addressable through better copywriting or a campaign refresh. It requires a brand platform built on the right psychological foundation. As Vantage's leadership stated directly: "You don't advertise your way out of a credibility gap. You earn your way out of it."

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The cancer center opening fourteen months from this engagement is the forcing function that gives this recommendation its urgency. What the brand needs before that launch is not a tagline update or a website redesign. It is a coherent identity that signals, clearly and credibly: Vantage is the system that shows up for serious care. The intake could not have been clearer on this point. The CMO stated: “Getting the brand right before that launch is not a marketing objective. It is a strategic one.” Every week of delay narrows the gap between when brand work can be completed and when the cancer center opens. The launch window is fixed. The brand work calendar is not.

What BrandLaunch™ makes possible for Vantage is a brand that converts the system’s operational strengths into patient-facing trust signals—at the specialty and high-acuity level where the revenue is. The community health infrastructure, the behavioral health leadership, the COPA accountability, the century of presence—all of it becomes a brand that says “we have been here, and we will be here, when it matters most” in a language the Warrior/Hero community recognizes as real. The commercial payor growth goals become achievable because the specialty trust architecture exists to support them. The cancer center opens not as a facility announcement, but as a brand moment—the culmination of a coherent narrative about what kind of health system Vantage has decided to be.

The SBCMO Health Architecture engagement that delivers this work is BrandLaunch™—and given the confirmed community composition data gap in this market, CommunityAtlas™ is a required add-on. The community psychographic model in this report is built on benchmark proxies calibrated for Appalachian market characteristics. CommunityAtlas™ provides primary-source

community psychographic research specific to Vantage's 29-county market—rather than regional averages—giving the brand platform a data foundation that is precision-fitted, not directionally approximated. Given the fourteen-month T5 timeline and the commercial payor growth targets, that precision matters. The combined investment for BrandLaunch™ and CommunityAtlas™ is **$60,000** in professional services. That investment exists on the same financial ledger as the $40.6 million midpoint specialty leakage estimate and the cancer center first-year volume at risk. The question is not whether Vantage can afford this work. The question is whether it can afford the alternative.

Section 6 — Recommendation Engine Output

Layer	Input	Output
Layer 1 – Trigger Floor	Brand Clarity Deficit, Post-Merger Integration Gap, Archetype Signal Gap—all confirmed	Floor: BrandLaunch™
Layer 2 – Signal Gap	Composite: 4.0 across D1–D6	BrandVoice™
Layer 2 – Perception Gap	CommunitySignal™ composite: 4.81	BrandVoice™

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Layer 2 – Credibility Gap	D5/D12/D11 composite with Pair 3 escalator applied: 2.49	BrandLaunch™
T6 Confirmed	Commercial payor 24% (<40% threshold); psychographic data gap; Tier 3 confidence only	CommunityAtlas™ add-on required
Final Recommendation	Highest of Layer 1 + Layer 2	BRANDLAUNCH™ + COMMUNITYATLAS™ = $60,000

This BrandAudit™ was conducted by SBCMO Health Architecture using proprietary methodology developed by Franklin Parrish. The BrandCore™ Segmentation Engine, CommunitySignal™ Composition Model, Brand Signal Scorecard, and Community Perception Alignment Matrix are proprietary SBCMO Health Architecture tools. For questions about these findings or to discuss next steps, contact Franklin directly at thesmallbizcmo.com

Section 7 | First 90 Days: Strategic Orientation

The first 90 days of brand work at Vantage are defined by three strategic priorities, in sequence: internal alignment, trust signal repair, and cancer center launch readiness. Internal alignment comes first because the brand cannot hold externally what it cannot sustain internally. At a system where legacy Ridgeway and Crestwood identities remain active in physician communications, patient-facing materials, and facility signage, any external messaging shift launched before internal coherence is achieved will fracture against its own contradictions. Trust signal repair—beginning with the brand elements most immediately undermining specialty care confidence—is the second priority, because the credibility deficit in specialty and high-acuity care decisions is accumulating cost every month the gap remains open. Cancer center launch readiness is the third and most time-constrained priority: the brand work that must be complete before the system's highest-stakes public moment is not a matter of preference. It is a matter of calendar. These three priorities are sequenced by urgency; they are not sequential in execution. All three require movement in the first 90 days.

The sequence matters as much as the priorities. Health systems with merger-legacy complexity consistently underestimate the damage misaligned external messaging inflicts when launched before internal alignment is achieved. A new brand narrative—however well-constructed—that encounters a physician still referring under a legacy system name, a staff member who introduces themselves with a different organizational identity, or environmental signage that contradicts the new messaging will not build trust. It will build confusion. And in healthcare, confusion is not a neutral condition. It is a trust deficit. In the intake, Vantage's

leadership was precise about this: "The brand gap we need to close isn't just between Vantage and its community. It's also between Vantage and itself." That observation defines the internal alignment priority. The brand cannot promise one thing externally and deliver another internally. The sequence—internal coherence first, external signal second—is the difference between brand work that holds and brand work that does not.

The three priorities above represent the strategic orientation. The specific brand framework, internal alignment protocol, and launch sequencing required to execute them—with the precision this moment demands—is the scope of BrandLaunch™, SBCMO Health Architecture's brand development engagement. BrandLaunch™ delivers:

- **Brand platform development:** Archetype-aligned brand positioning, voice standards, and message architecture built specifically for the Vantage market and the Warrior/Hero-dominant community it serves
- **Internal activation protocol:** Physician alignment program, staff identity integration, and leadership communication sequencing that ensures the brand holds from the inside out before any external messaging shifts
- **Patient-facing messaging system:** Specialty care credibility signals, high-acuity trust narrative, and the brand language that positions the cancer center as a destination before its doors open
- **Launch sequencing against the cancer center calendar:** A phased activation plan that builds brand equity across the fourteen-month window and captures the launch moment at full brand readiness

The full First 90 Days implementation roadmap is the opening deliverable of that engagement.

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Appendix — Supporting Data

Appendix A: Full R1 Brand Signal Scoring Table

All 12 dimensions across five touchpoint categories. Scores reflect average across assessed materials and facilities. D5 shown as banded composite.

Appendix A — R1 Full Scoring | Strong = 7–10 | Moderate = 5–6 | Weak = 1–4

Dimension	Website	Social	Pt. Materials	Env. / Signage	Advertising	Avg Score	Tier
D1 – Visual Consistency	5	4	3	3	5	4.0	Weak
D2 – Voice Clarity	4	5	4	3	4	4.0	Weak
D3 – Message Hierarchy	3	4	3	3	3	3.2	Weak

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D4 – Archetype Signal Clarity	4	5	3	4	4	4.0	Weak
D5 – Trust Credibility (Banded)						4.55	Weak
Band 1 – Routine Care (15%)						7.5	Moderate
Band 2 – Specialty Care (35%)						3.5	Weak
Band 3 – High-Acuity (15%)						3.0	Weak
Band 4 – Loyalty/Advocacy (35%)						5.0	Moderate

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D6 – Emotional Register	4	5	3	4	4	4.0	Weak
D7 – Mission Clarity	5	5	5	5	5	5.0	Moderate
D8 – CTA Coherence	4	4	3	4	4	3.8	Weak
D9 – Identity Mirror						4.0	Weak
D10 – Relationship Signal						4.0	Weak
D11 – Impact Legibility						3.0	Weak
D12 – Trust Architecture						2.0	Weak

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Note: D5 is a weighted banded composite score; touchpoint columns not applicable. D9–D12 are system-level experience dimensions; touchpoint columns not applicable at this tier.

Appendix B: R2 CommunitySignal™ Composition — Full Archetype Detail

Appendix B – Community Archetype Composition + Signal Ratings

Archetype	Est. % of Community	Weighted Composite	Signal Rating	Gap Severity
Warrior/Hero	~20%	3.63 / 10	Gap	Critical–dominant segment, largest gap
Orphan/Citizen (Everyman)	~15%	4.87 / 10	Gap	High–specialty trust absent

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Caregiver	~14%	6.10 / 10	Partial	Medium–operational strength, brand gap
Destroyer/Outlaw	~12%	3.70 / 10	Gap	High–institutional messaging produces resistance
Innocent	~10%	5.55 / 10	Partial	Medium–routine care partial, specialty absent

Data Confidence: Tier 3 (Regional benchmark proxies calibrated for Appalachian market characteristics). Primary community psychographic research (CommunityAtlas™) would upgrade to Tier 1 for this market. Current estimates are directionally reliable for brand diagnosis; precision increases with primary data.

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Appendix C: CommunitySignal™ Composition Model — Data Detail

Parameter	Detail
Data Confidence Tier	Tier 3 – Regional benchmark proxy. No primary psychographic research available for this specific market at time of engagement.
Source Description	Appalachian regional market psychographic benchmarks; secondary academic research on Appalachian health attitudes; SBCMO Health Architecture benchmark library (comparable regional systems)
Market Definition	29-county, 2-state service area; predominantly rural and small-city Appalachian communities; COPA-protected market
Dominant Archetype	Warrior/Hero (~20%)–agency-oriented, action-framed health decisions; low institutional deference; trust through demonstrated commitment

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Benchmark Comparison	Comparable Appalachian regional markets: Warrior/Hero typically ranges 18–22%; Vantage community estimate within benchmark range. Caregiver below typical range (14% vs. 18–20%), consistent with lower household density and family network dispersion.
Upgrade Path	CommunityAtlas™ engagement upgrades to Tier 1 (primary psychographic research, n=800+ community sample) for this specific 29-county market. Required for full brand execution precision.

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Appendix D: Full 3C Competitive Scan

Appendix D – 3C Competitive Scan | Tier 1 = Emerging | Tier 2 = Established | Tier 3 = Institutional

Entity	Type	Archetype Signal	Visual Tier	Positioning Angle	Overlap
Appalachian University Medical Center	Competitor	Sage	Tier 2	"Where the best go for serious care"–academic authority, 60–90 min drive	High–specialty + oncology
Commonwealth Regional Health	Competitor	Ruler	Tier 2	Institutional scale, employer relationships, administrative sophistication	Medium–employer + VBC
Mountain Care Physician Alliance	Collaborator	Caregiver	Tier 2	"Your doctor's home"–patient relationship	High–PCP + referral

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				primary; referral pathway potential	
Regional Employer Consortium	Collaborator	Ruler	Tier 1	Cost efficiency, productivity framing; benefit design relationships	Medium–employer + benefits
Healthcare as Cultural Category	Category	Sage / Hero blend	Tier 2	Trust through evidence + community accountability; COPA obligation as expectation	N/A

Vantage Regional Health (Current)	This System	Everyman / Ruler	Tier 2	Community infrastructure, merger scale–Warrior/Hero white space unclaimed	← Reposition

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