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The Camden Coalition of Healthcare Providers: Weighing Opportunity with Capacity

Introduction

Though it was particularly hot for the season, Dr. Jeffrey Brenner, Executive Director and CEO of the Camden Coalition of Healthcare Providers (the Coalition), thought the day was especially warm. From a conference room on the eighth floor of 800 Cooper Street in downtown Camden, New Jersey, Brenner could see the heat radiating off the pavement from his seat by the window. Turning back to face his executive leadership team (ELT), he could tell that recent tensions were adding to it.

It was June 2015, and by all accounts the Coalition was flourishing. Among other activities, they were in the midst of rolling out a new regional Accountable Care Organization, expanding their technical assistance contracts, and testing the efficacy of their Care Management Initiatives. There was no doubt that the Coalition was busy, but, Brenner reflected, they were always busy. What made the recent weekly meetings tense was not what they were currently doing, but what Brenner saw as a next step: a Housing First demonstration project.

Today's conversation had been another in a string of difficult meetings, in which they went back and forth on whether it was the right move to pursue the Housing First demonstration project. They already had partners in the housing sphere and didn't want to provide duplicative services. Yet, many of their patients had been disqualified from the existing housing providers, and this opportunity could directly benefit those patients. Even if they did choose to go ahead with it, how would they build and operationalize the initiative? There was no service funding, and key questions about stakeholders, project placement (to place internally or with external partners), branding, staffing, workflows, funding and the scope of the project remained unanswered.

Though they had yet to come to a consensus, Brenner was not displeased with the progress and quality of the discussions. He knew that forcing high-risk or high-stake decisions too quickly would end poorly and feared that without complete support from his ELT the demonstration project would surely fail, with deleterious repercussions for the Coalition. However, he also felt that they couldn't simply pass up this opportunity, especially when it could directly impact so many of their patients. Closing the meeting, he suggested everyone take some time to sleep on it, think it over, digest it and "talk it through with their kitchen cabinet" before coming back next week. "We are not going to walk out of the door today with a go or no-go decision," he reminded his team. "We are going to chew on this for a little while and evaluate our options."

Case Writer Sophia Arabadjis, MSc, Case Writer Zara Ibrahim and Director of Research and Curriculum Development Erin E. Sullivan, PhD prepared this case study for classroom discussion. It is not intended to serve as an endorsement, source of primary data, or illustration of effective or ineffective health care management or delivery. Any patient data in this case has been de-identified in compliance with HIPAA and other regulations governing confidentiality, and any used patient names are fictitious .Cite as: Arabadjis, S., Ibrahim, Z. & Sullivan, E. (2016). The Camden Coalition of Healthcare Providers: Weighing Opportunity with Capacity (A). Boston, MA, USA: Harvard Medical School Center for Primary Care.

Camden and the Coalition

The Coalition was born from informal roots. In the early 2000s, frustrated and challenged in his own private practice, Dr. Jeff Brenner formed a breakfast club for local practitioners to discuss their experiences practicing in Camden, New Jersey. Over the years, the breakfast club grew from a handful of physician providers to include members of other professions and disciplines from all across Camden, including family physicians, internists, pediatricians, nurse practitioners, school nurses, health service organization members, physician assistants, midwives, and podiatrists. As the number of attendees grew, the club adopted by-laws, formed a planning board, scheduled discussion topics, and began to invite speakers from local specialties and services as well as national health administrators. Over time, the group formalized its structure and objectives, and in 2006, the Coalition became a nonprofit.

In 2011, the Coalition skyrocketed into the limelight when Atul Gawande's article, "The Hot Spotters," was published in The New Yorker.[1] Since then, Brenner and the Coalition received numerous grants, press, and awards (see **Exhibit 1, Grants Awarded to the Coalition**). Mirroring its growth in fame, the Coalition expanded rapidly; between 2011 and 2015, the Coalition grew from 11 to more than 70 employees.

A Complex City

From his seat at the table, Brenner could also see the Delaware River — the river that, like so many things, divided the city of Camden from Philadelphia. Brenner knew that Camden's residents and health care providers faced a complex set of variables on a daily basis that made achieving health in Camden difficult. A heavy socio-economic burden, potential challenges around communication and health literacy, limited resources, and regular violence all contributed to the context in which the Coalition was trying to achieve its mission and vision (see **Exhibit 2, Mission, Vision, and Values of the Coalition**).

Once a wealthy settlement with a rich industrial and Quaker history, in 2015 the city of Camden numbered among the poorest, most corrupt and dangerous cities in America. In 2013, the unemployment level was more than double the state average, and nearly 40% of Camden's residents were living below the federal poverty level (see **Exhibit 3, Selected Demographics of Camden, New Jersey**). In terms of educational attainment, while 35.8% of New Jersey state residents obtained a bachelor's degree or higher, only 7.6% of Camden residents held the same degrees.

In addition to socio-economic challenges, the city also faced a violent history. In the early 1990s, Camden's crime index[2] numbered above 15,000. Though it had been steadily declining[3], as of 2013 the crime index still remained above 5,000. By comparison, the crime index for the State rested just under 3,000.[4]

[1] Atul Gawande, "The Hot Spotters," *The New Yorker*, 86:45 (January 2011):41

[2] Since the early 1930s, the Federal Bureau of Investigate (FBI) has compiled crime statistics from law enforcement agencies across the nation using the Uniform Crime Reporting program (UCR). The program allows the FBI to compare rates of violent crime (murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault) and property crime (burglary, larceny-theft, and motor vehicle theft) across communities within the United States. The crime index is a single aggregate statistic designed to measure the prevalence of crime across communities.

[3] Geoff Mulvihill, "Murder rate falls in impoverished New Jersey city," Associated Press, CNS News, January 2, 2015. http://www.cnsnews.com/news/article/murder-rate-falls-impoverished-new-jersey-city. Accessed April 2015.

[4] CAMConnect, *KNOW YOUR CITY: Camden City Crime Trends from 1989 to 2014*, New Jersey Uniform Crime Reports 1989 – 2014, available at http://www.camconnect.org/datalogue/2015CrimeAnalysis.pdf, accessed April 2015.

Data-Driven Beginnings

After completing his family medicine residency in 1998, Brenner moved to Camden and began practicing at a local medical office for Camden's urban, under-served community. In 2003, Brenner opened his own private practice, Camden Family Medicine. According to Brenner, practicing in Camden was "both delectably fun and horrifically terrible." On the one hand, Brenner valued the small size of the city, felt he had close relationships with all of his patients, and had a cutting-edge private practice. His three-room office boasted an electronic medical record, open-access scheduling, and team-based care. On the other hand, Brenner also struggled to practice in Camden; he faced mounting debt from shifting Medicaid policies, and both he and his patients faced many daily stressors from living in Camden:

> My metaphor for the office was that it was like a spring and people come in with all this really intense stress, and I can't fix all of that but I can bounce them back up and get them back into the game of life. Camden is a very, very stressful place to be and all day long you're really dealing with things that are symptomatic of stress and stressors that are just enormous things that people can't change.

Brenner's practice suffered from the declining Medicaid reimbursement rates, and over the years mounted significant debt. It became clear that the practice would never be sustainable and that, for all its advancements, it was "just crumbling." Brenner closed the practice in 2009.

Around the same time, the Camden Police Department was also in upheaval and Brenner was asked to serve as one of two community representatives on a police reform commission for the city. The commission invited members of the New York City Police Department (NYPD) to come consult, and it was in this capacity that Brenner was exposed to CompStat, and the idea of hot-spotting.

The CompStat model relied on four key principles: accurate and timely intelligence, rapid deployment of resources, effective tactics, and relentless follow-up assessment. At each precinct, incident reports were visually displayed using pushpins and maps so that areas of high crime activities became easily identifiable. These areas were termed "hotspots." As each precinct tracked its own data, accountability and performance measures were also clarified.

In his work with the police reform in Camden, Brenner realized that there were similarities in the health care system: "We had all the failures and needed a lot of the same things. We needed strategic use of data moving in real time. We needed to answer the question of accountability." So, as the decade came to an end, Brenner turned this method to his work with the Coalition and began to examine claims data from Cooper Hospital.

By 2009, Brenner realized that to really gain a clear picture of utilization patterns in Camden, he needed to understand how patients might float between the three different hospital systems: Our Lady of Lourdes Medical Center, Cooper University Health Care, and Virtua Health. Armed with only Cooper's data he approached CAMConnect, a local independent nonprofit dedicated to expanding and democratizing access to data and information for those who lived and worked in the city of Camden.[5] CAMConnect provided the Coalition with technical assistance in acquiring the additional datasets, linking patients across systems with a probabilistic method and geo-coding the data.

[5] CAMConnect, "About," CAMConnect Website, http://www.camconnect.org/about.html, accessed October 25, 2015.

Aaron Truchil, the Director of Data and Research at the Coalition, was working for CAMConnect in 2009 and was took part in the initial analysis to understand and visualize the hospitals' claims data. Together Brenner and Truchil mapped health care utilization against city blocks (see **Exhibit 4 Spatial Analysis of Camden Hospital Costs**) like the hot-spotting CompStat method, and ended up "stumbling upon a little problem that is now pretty ubiquitous," as Truchil described it. Using the claims data, Brenner and Truchil discovered that 30% of hospital receipts in Camden were concentrated in just 1% of patients (see **Exhibit 5, Camden New Jersey Cost Curve**). On average, these patients had 4.5 emergency department (ED) visits per year, 5.3 inpatient hospitalizations per year, and each cost the system $673,000 in charges ($73,143 in receipts) (see **Exhibit 6, Camden Profile of Super-utilizers**). Further analysis revealed that these patients were often medically and socially complex cases who cycled through different emergency departments and hospital admissions. They were the "super-utilizers" of Camden's health care services.

Truchil and Brenner's initial analysis of the three hospitals' claims data set an important precedent for the Coalition: the emphasis on data and data sharing. As one staff member illustrated, "The data sharing starts the conversation, it started a conversation nearly 10 years ago around this 1% [of super-utilizers]... It's so important to get people to collaborate and to see their shared interests. And if you can't pull the data out of their silos, if we can't get people collaborating around the table, then it's really hard." Brenner had extensive experience bringing competitors to the table and negotiating agreements. At the Coalition, Brenner was widely credited for building relationships with administrators, clinical champions, and upper level executives that secured the initial data sharing between the three Camden hospitals.

The Role of Data

In 2015, data were integrated at every level of the Coalition's activities and served a variety of purposes at the Coalition. Data were used to articulate and clarify problems, to engage a diverse array of stakeholders, and to unify and organize people around a common mission. With a team of six, the Data and Evaluation department, also known as the "Datashop," worked to make data accessible and available to all of the departments. However, the varied activities of each department placed different demands on the Datashop. Truchil explained:

> We're sort of this weird organization that there's no sort of analog to. There's a mix of the heavy clinical side, which is embedded in the complex care. There's the mix of redefining the payment structure through the ACO. There's the heavily policy side, which is trying to remove some of the systemic barriers that our patients face, and the data side that's supporting all of these different axes.

The team sourced data from an ever-expanding list of contributors, including data from the three local hospitals, clinical laboratories, perinatal risk assessment data, homelessness data, housing data, prescription data, education data, corrections data, and local police crime statistics. They then linked and compiled the data for a variety of external and internal projects.

Care Management Initiatives

Stemming from Brenner and Truchil's initial research, the Care Management Initiatives department (CMI) aimed to improve health and reduce unnecessary hospital utilization among Camden's super-utilizer population through a biopsychosocial[6] intervention. The intervention had been iterated in many

[6] George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196 (April, 1977): No. 4286.

forms and each iteration further focused on addressing patient complexity— specifically medical, psychological and social needs of patients— in order to reduce unnecessary utilization. To this end, a community-based and multidisciplinary intervention was developed that provided a milieu of wrap-around services for Camden's super-utilizers. Services included home visits, accompaniment for medical and nonmedical appointments, medication reconciliation, care planning, access to and advocacy for social benefits, and outpatient coordination services.

CMI Team and Intervention Protocol

With 27 individuals, the CMI department, also referred to as the "clinical team," was the largest of the Coalition's departments. Team members ranged in expertise and profession, and included registered nurses (RNs), licensed practical nurses (LPNs), community health workers (CHWs), social workers (SWs), AmeriCorps members as health coaches, as well as program managers and strategic oversight (see **Exhibit 7, CMI Team Composition**). Additionally, in 2014, the CMI team began a two-year subcontract with Rutgers University Behavioral Healthcare funded by the Center for Medicare and Medicaid Services to provide for a behavioral health consultant.

Overseen by Senior Director Kelly Craig MSW, the CMI was broadly divided into three teams: hospital operations, community operations and social work operations. The intervention began with the hospital operations and intervention enrollment. Potentially eligible patients were identified through the Camden Health Information Exchange (HIE), a regional health information database developed by the Coalition (see **Exhibit 8, The Coalition's Intervention Paradigm**). In an automated process, the team received a daily electronic list of patients who had been 1) admitted to one of the two admitting hospitals (Our Lady of Lourdes Medical Center or Cooper University Health System) in the preceding 24-hours and 2) had two or more inpatient visits in the past six months. With the HIE list, the enrollment specialists approached patients about participating in the intervention and began a process of relationship building. These initial meetings took anywhere from 45 minutes to several hours and involved a description of the intervention, discussion, and preliminary care planning.

Though verbally unscripted, the enrollment process set the tone of the intervention and illustrated the partnership entailed in participation. As Jason Turi, the associate clinical director of the CMI team explained:

> We don't convince anybody. They [patients] vocalize their needs and they listen to what this [the intervention] is, and then they make a decision to be a part of the relationship [with the clinical team]…It's more of, "Okay, this is something that could potentially benefit and support me [the patient] in getting my needs met."

After the patient consented to the intervention, an initial assessment was completed by the hospital operations social worker. In addition to the enrollment specialists and social worker, health coaches and an RN care coordinator helped transition eligible patients. After consenting, another electronic list was generated and passed on to the managing RNs of the two care management teams, Team Awesome and Team Supreme. These two teams began the wrap-around services of the intervention upon patient discharge.

Each team had several core CHW-LPN pairs that interacted with patients. The managing RNs assigned patients to a specific CHW-LPN pair based on panel load. CHWs and LPNs were jointly responsible for

panels of 8-15 patients. Health coaches also flexed in and out of each small panel as needed. The clinical team engaged about 70 patients at a time.

Within three days of discharge, the CHW-LPN pair aimed to follow up with patients in person on discharge plans and care planning. Additionally, the CHW-LPN pair sought to have all patients seen in one of Camden's primary care facilities within seven days of discharge. After the primary care visit, CHW-LPN pairs visited their assigned patients in person every week. CHW-LPN pairs offered various services tailored to an individual patient's needs, including on-going medication reconciliation, securing social services such as housing and transportation, and connection to local community resources such as day programs and religion-affiliated programs. They also spent time advocating on behalf of patients and arranging services where necessary.

Health coaches also played a pivotal role in the intervention. Through a partnership with AmeriCorps, health coaches were recruited through a program called Community HealthCorps, which targeted young college graduates interested in pursuing medicine, social work, or public health. Each August, the Coalition recruited a new cohort of ten health coaches who were placed at one of four locations: the Urban Health Institute at Cooper University Hospital, a local federally qualified health center called CAMcare, or directly within the CMI on the hospital operations or community operations teams (Team Supreme and Team Awesome).

In each setting, health coaches had slightly different roles, but one of their primary responsibilities was accompaniment and navigation. Health coaches escorted patients to primary care and specialty care appointments and acted as patient advocates; they performed home visits and care planning; and they also facilitated connections to social services by accompanying patients to get IDs or renew driver's licenses. A central premise of the Coalition's intervention was that social challenges, such as housing instability or transportation concerns, impacted people's ability to achieve health and remedy medical concerns. An important part of the Coalition's intervention, and part of the role of the health coach, was to help patients address and solve social difficulties. Many former AmeriCorps members chose to stay on after their year as a health coach in full-time positions with the Coalition. In 2015, the Coalition expanded their cohort to fourteen health coaches, including additional patient-facing placements at primary care practices in Camden.

In addition to the wrap-around services provided by the CHW-LPN pair and the health coaches, social work operations provided further support for the community operations. The social work operations team was smaller and comprised of a behavioral health consultant, program manager and two social workers, one of whom specialized in housing. This team was available as needed and worked with patients from both care management teams to aid in services and expertise peripheral to the CHW-LPN pair and health coach, such as behavioral health assessments, access to benefits, and housing instability.

All visits and time spent on behalf of patients were carefully tracked and monitored using TrackVia software (see **Exhibit 9, TrackVia Screenshot & Score Card**). Specially designed and preloaded onto field-ready iPads, TrackVia allowed each CHW-LPN pair, as well as social workers and health coaches, to carefully monitor and record actions and steps for each visit. Additionally, individual patients on each panel were color-coded by date of last visit and total hours logged. iPads were also connected to the HIE, which allowed LPNs immediate access to discharge plans, medications, and physician care plans online. The intervention aimed to engage patients for a period of less than three-months, and the average time-to-graduation for patients hovered at 95 days.

"Housing is the Best Pill": Putting Housing First

Kelly Craig, as Senior Director of the CMI, had long known that housing instability was an issue for roughly 40% of their patients. Over the course of her tenure at the Coalition, Craig had been instrumental in adding resources to the CMI team, such as housing specialists, to address as much of the need as possible, but the Coalition's efforts and successes often fell short of total need.

One such program was the 2012 Home Health Recover Pilot (HHRP), a housing program that aimed to provide five homeless or housing-unstable individuals with rapid permanent housing, access to primary care services, and person-centered recovery based on supportive housing models. The target outcome was to improve the individual's medical and mental health, and in so doing, reduce ineffective and costly over-utilization of emergency health care systems. To deliver the 18 month pilot, the Coalition partnered with three other local organizations: the Collaborative Support Programs of New Jersey (CSP-NJ), the Community Planning and Advocacy Council (CPAC), and the United Way of Camden County (see **Exhibit 10, HHRP Partners**). The Coalition identified eligible program participants and provided reconnection to primary care services; CPAC acquired suitable housing, which United Way provided furnished; and CSP-NJ provided outreach and assistance for patients from necessary documentation to the majority of wrap-around services once patients successfully entered housing (see **Exhibit 11, Processes and Roles of HHRP**).

Looking back on the pilot, the Coalition faced many difficulties in filling the five vouchers. The housing voucher process itself was fraught with exclusion criteria that often disqualified many of the Coalition's patients for medical complexity, criminal background, or continued substance abuse. "Seeing these really good success stories, which were not as frequent as we would like," Craig recalled, "and then complaining all these years about the lack of resources… It didn't feel like there were any immediate solutions."

Taking these challenges back to the executive leadership team, it quickly became apparent not only that there were immense barriers to housing for the Coalition's homeless patient population, but also that the CMI's core intervention and wrap-around services simply did not work for homeless patients. If the Coalition was going to achieve its mission and outcomes, they would need to address this gap and develop a program that was specifically intended for homeless CMI patients - programs like Housing First.

Housing First: Adoption and Requirements

Developed in 1992 by Dr. Sam Tsemberis at Pathways to Housing, the Housing First model is an evidence-based,[7,8,9] low-barrier model that provided rapid access to permanent supportive housing for homeless individuals with mental health and addiction issues. Supportive treatment services included mental medical health wrap-around care, education and support programs, and employment opportunities/coordination. The model is recognized as being highly successful: generally, over 80% of individuals remain in permanent housing, as opposed to about 30% of shelter graduates. Additionally,

[7] Danielle Groton, "Are Housing First Programs Effective? A Research Note," *Journal of Sociology & Social Welfare* 40 (2013):1.
[8] Leyla Gulcur et al., "Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes," *Journal of Community & Applied Social Psychology* 13 (2003):2.
[9] Kirst Marrit et al., "The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness," *Drug and Alcohol Dependence* 146 (January 2015):1.

Housing First has been credited for promoting a sense of home, self-determination, community and choice through a "scattered site" (non-housing development) approach[10,11].

The Housing First model was developed in stark contrast to the predominant approach known as Continuum of Care.[6] The Continuum of Care encompasses several different programs, but generally all Continuum of Care programs follow the same basic principle: in order to be "housing ready," homeless individuals need to "graduate" from different, sequenced, periodic requirements.[5] In the beginning, barriers are low, with drop-in centers and outreach. As individuals move into different living arrangements with varying levels of support, the conditions increase (for example, sobriety and "dry shelters"). However, in order to move into residential housing programs, conditions often include complete abstinence from drugs and alcohol, enrollment in mental health treatment, clinical improvement, and lack of a criminal history. In Camden, NJ, the Continuum of Care programs were the predominant approach to housing in Camden.

All Roads Lead to Trenton: A Demonstration Opportunity

In the fall of 2014, about two years after the start of the HHRP pilot, the Coalition organized two site-visits as part of the Good Care Collaborative, a statewide advocacy group of providers, legislators, and other stakeholders from across the health care spectrum in New Jersey. The Collaborative is committed to advocating for sensible Medicaid reform, informed by visiting and studying models of "good care delivery" across the state. The two site visits took stakeholders to successful examples of Housing First initiatives in Philadelphia, PA (Pathways to Housing) and neighboring Trenton, NJ (Greater Trenton Behavioral Healthcare).

Shortly after the visit, Mark Humowiecki, legal counsel and Director of External Affairs, received a call from the New Jersey Department of Community Affairs with a verbal commitment for 50 Section Eight housing vouchers, to be earmarked for a Housing First demonstration project in Camden (see **Exhibit 12, Details on Section 8 Housing Vouchers**). The total value of the 50 vouchers was between $37,000-$40,000 per month, but there would be no additional funding provided for services or administration of the program.

It was this issue that had been at the core of the executive leadership's discussions. Brenner's team knew that the Housing First demonstration would be a difficult departure for the Coalition, should they choose to take it on.

To implement a high-fidelity Housing First model required specific resources. The supportive services are administered through a 24-hour on-call multi-disciplinary supportive housing team, which must be available seven days a week, and provide services directly connected to local resources. Supportive housing teams within the Housing First model strongly integrate harm reduction models of care, and allow individuals to choose what programs they engage in and with what frequency. Individuals may also choose to deny any services, though it is strongly recommended that they meet with a staff member at least bi-monthly and that they pay 30% of any income towards housing. Non-compliance with these requirements, however, does not affect housing status. The Coalition estimated that the total cost per

[10] Pathways National, "Housing First Model," Pathways National Website, https://pathwaystohousing.org/housing-first-model, accessed April 20, 2016.

[11] Elizabeth Buck, Jeffrey Brenner, "There's no place like home in health care: Housing the homeless is key to controlling costs," June 16, 2014, post on blog "Health Cents, Philly.com," http://www.philly.com/philly/blogs/health-cents/Theres-No-Place-Like-Home-in-Health-Care-Housing-the-Homeless-is-Key-to-Controlling-Costs.html, accessed April 2016.

patient, including programmatic, non-rental housing-related costs and the supportive services, would be up to $20,000 per year (see **Exhibit 13, Statements of Revenue & Expenditure**).

In addition to the 24/7 supportive housing team, Housing First faced several other programmatic and pragmatic challenges in terms of implementation in Camden. As a harm reduction model, all frontline staff involved in patient care would need to be comfortable with harm reduction methods and approach. Insurance, landlord relations, maintenance, workflows, partnerships with addiction and behavioral health services, payment structures, staffing, overall budget commitments, acquisition of housing vouchers and evaluation procedures would all need to be addressed in order to implement the program.

The opportunity posed by the State's offer and the specific requirements of the Housing First program crystallized into two questions during the executive leadership meetings: if they should take the vouchers, and if they did, how would they operationalize the Housing First demonstration?

Internal or External Partners: On-Going Challenges with Initiative Capacity

The Housing First demonstration project would not be the first time the Coalition implemented a new initiative. Over the years, Brenner and the ELT had overseen the development of several programs and initiatives at the Coalition that were intended to support and facilitate aspects of the intervention (see **Exhibit 14, ELT Members and Responsibilities**). Ranging from local to national in scope, the Coalition's various programs spanned across health care, social services, and the government (see **Exhibit 15, Organizational Chart**). If the Coalition chose to pursue the Housing First demonstration project, Brenner would need to learn from past successes and mistakes. In operationalizing and maintaining various initiatives, capacity had always been a challenge. In particular, the ACO demonstration project, the Clinical Redesign Initiatives, and the Technical Assistance Program held important lessons for the Coalition about capacity. Key considerations included how to engage stakeholders, where to locate initiatives (internal and/or external partners), how to delegate responsibilities and processes, funding streams, and matching scope with capacity. Brenner and the ELT reflected on these past experiences during the decision-making process for the Housing First demonstration project.

<u>Application for the Medicaid ACO Demonstration Project</u>
When the Affordable Care Act (ACA) was introduced in 2011, the Coalition was well established in Camden and had a model of organizing a community in place. Brenner saw an opportunity to use the ACO framework and incentives to expand the Coalition's reach within the community. However, instead of tying the ACO model to one health system or facility, they decided to broaden the reach, and partners, involved in the ACO. The Coalition's ACO would be geographic in nature; it would span Camden's five zip codes and encompass all resident Medicaid beneficiaries. The goal of orienting the ACO in this manner was to force cooperation between the different health care facilities within the city, in order to best serve Camden's Medicaid population. As Len Terranova, Chief Strategy and Information Officer, explained, "In a city like Camden, with the kind of patients that are covered by Medicaid, you can't do it just inside of one hospital system." Additionally, in its decision to pursue an ACO model, the Coalition knew it had to integrate social services and behavioral health services into its ACO, even though, in New Jersey, these services were traditionally siloed – both in terms of infrastructure and payment processes.

In response, Brenner assembled a small ad hoc team of lawyers and lobbyists to jointly draft a bill for a Medicaid ACO Demonstration Project based on the Coalition's model. Driving his old Subaru, Brenner proceeded to travel from legislator to legislator, talking to interest groups, hospital associations, medical

societies, and all other major players to advocate for the bill. Chapter 114 was subsequently introduced and passed unanimously.

The demonstration project established a three-year trial, in which nonprofits in conjunction with local hospitals, clinics, pharmacies, health centers, and other care organizations partnered to address five major goals that included increasing access, improving quality and outcomes, and reducing unnecessary and inefficient care (see **Exhibit 16, Chapter 114**). In exchange for these extended services and goals, the Medicaid ACOs would become eligible, under the law, for gain-sharing programs in which a percentage of the cost-savings would be re-distributed to Medicaid ACOs upon proof of cost reduction. The Medicaid ACO certification process was fairly stringent and included specific regulatory bodies and provisions. Any organization applying for certification needed to have the support of all the general hospitals in the area, at least 75% of the qualified primary care providers and at least four behavioral health providers in the service area. Additionally they needed to be a recognized nonprofit and serve a minimum of 5,000 Medicaid beneficiaries within a designated geographic region. Other requirements included a verified and approved gainsharing scheme, community member engagement, and executive board composition.

After a rigorous process of reviewing comments and writing regulations, the applications for the Medicaid ACO Demonstration Project opened in June of 2014. Brenner submitted the Coalition's application on July 3, 2014.

Medicaid ACO in Practice

As of June 2015, Brenner was still waiting to hear if the State would approve the Coalition's application to be part of the demonstration. However, since submitting their application, Brenner, Humowiecki and the ELT had overseen the Coalition's transition to a functioning Medicaid ACO. Under the ACO model, the Coalition was accountable for roughly 37,000 Medicaid beneficiaries in the eight Camden zip codes. For Camden's super-utilizer population, this orientation around a geographic area was crucial and allowed for appropriate compensation and accountability even as patients traveled through the different Camden health systems.

In addition to being a regional ACO, the Coalition's ACO model differed from other ACOs in its structure. Per the Demonstration Project, the Coalition would eventually receive a percentage of the money saved through calculated adverted health care costs (shared savings). In its application, the Coalition created the Community Advisory Council (CAC) to decide how these savings would be distributed amongst the ACO's partners (see **Exhibit 17, Partners of the Coalition**). However, instead of delivering the shared savings post-Medicaid reimbursement like other ACOs, the Coalition decided to incentivize both its patients and partnering organizations by providing real-time reimbursements (see **Exhibit 19** for details).

Drawing on the health profile and demographics of their attributed Medicaid beneficiaries, their CMI patient panels, and their prior experience with community partners, the Coalition leadership decided on a few goals for their ACO collaborators: seeing patients after they were discharged from the hospital, connecting repeat ED-users with primary care, and extending visits. These goals were eventually distilled into one extended metric: a primary care visit within seven days of discharge for an extended 25-30 minute visit, including medication reconciliation for all recently discharged patients. To help get patient and provider buy-in, the Coalition developed a campaign around the single metric, which they called the seven-day pledge (see **Exhibit 18, The Seven-day Pledge**).

The funding for the ACO reimbursements came solely from the Coalition's contracts with Medicaid managed care organizations (MCOs). The Merck Foundation provided additional grant funding to support the back-end infrastructure of the ACO because it had an interest in medication adherence and wanted to gain a better understanding of their customer base. Their efforts helped to fund the provider-engagement and quality-improvement activities of the seven-day pledge and portions of the HIE. The Nicholson Foundation also provided funding, but for different reasons; the Nicholson Foundation was committed to addressing the complex needs of vulnerable populations in New Jersey's urban and underserved communities.[12] Rallying diverse funders around a single project like the ACO reimbursements meant carefully articulating the value of the Coalition's services. It was a problem that Terranova mulled over constantly:

> We have a value to pharma companies. We have a value to hospitals. We have a value to primary care providers. We have a value to payers. We have a value to the patients themselves, for certain. And we have a value to the state government. But the problem is all of those people, they're all separate funding streams. So how do you get them to coalesce around a problem… that has a little bit of value for each, and still fund something without having it be completely scatter shot, like one-offs?

Brenner also knew that the value conversation needed to go much further, that the ACO model and the Medicaid demonstration project were not a guaranteed ticket to the initiative's sustainability. Part of the ACO revenue stream stemmed from the gainsharing, or shared savings, program. Calculated as a percentage saved, ACOs faced diminishing returns every year and the prospect of eventually saving to efficiency or receiving no additional funding. Brenner and Terranova viewed the ACO as a step in a larger plan to achieve payment reform, potentially in the form of global budgeting systems or long-term bundled payments, but they hadn't worked out the details. On one aspect, however, they were certain: the demonstration project was an opportunity to prove the concept. To do that, though, they would need to be deliberate about the building capacity of their ACO partners, which was largely handled by the Clinical Redesign Initiatives (CRI).

Clinical Redesign Initiatives: Lessons Learned in Primary Care

The CRI's approach and activities in the ACO were heavily influenced by the Coalition's prior attempts to improve care delivery and outcomes in the city's primary care practices. A team of seven, the department grew organically with various grants and initiatives.

Camden Citywide Diabetes Collaborative: Striving for PCMH

In 2009 the Coalition was awarded a $2.5 million, five-year Merck Company Foundation grant under the Alliance to Reduce Health Disparities. At the time, Brenner partnered with a small team to try to improve diabetes care at the patient, practice, and community level. One of the larger goals of the grant, however, was to certify 10 community-based primary care practices as patient-centered medical homes (PCMH) (see **Exhibit 19, Program Goals** and **Exhibit 20, 2008 PCMH Guidelines**). To accomplish this, the team began by engaging all the primary care practices across the city and conducting a needs-assessment for resource management. The team then launched a series of pilot projects to address these needs and to change diabetes care delivery. At the same time, the HIE was just beginning and the team also decided to try to introduce it into the primary care practices. However, by 2011 the team realized that transforming

[12] The Nicholson Foundation, "The Nicholson Foundation: Who we are," Nicholson Foundation Website, https://thenicholsonfoundation.org/who-we-are, accessed October 20, 2015.

all ten practices would not be feasible. As one team member recalled, "Expectations of transforming all of the primary care practices to PCMH was unrealistic and overwhelming. The administrative burden was huge, implementing change was ineffective, and the impact was short-lived due to the diverse cultures and staff make-up at each practice. Despite all of these challenges, we were able to form deep relationships."

At that point, Brenner returned to Merck and explained the situation: that achieving PCMH status would be too much of an administrative burden for both the Coalition and Camden's primary care practices. Instead, Brenner and the Coalition proposed that the grant continue to focus on completing the various pilot projects and creating a public educational body to disseminate information about nutrition and diabetes in a meaningful way across the city. The Merck Company Foundation agreed to continue funding the various projects. Only the nutrition and diabetes educational body was still in existence as of June 2015.

Together on Diabetes: Challenges with Quality Improvement

In 2011, the Coalition received another similar grant from the Bristol-Myers Squibb Foundation for $3.5 million over five years to focus on diabetes management and practice transformation. The objective behind this grant was to work with a few practices in-depth, provide them with resources and tools for practice transformation, and to institute regular quality improvement. To determine practices, the Coalition announced a request for proposals to the city. Two practices were selected to participate in the grant: Virtua-Camden and River Road primary care. The coalition then assembled separate care management teams (not under the clinical team auspices) to work directly with the two practices.

For two and a half years the separate care management teams and grant administration at the Coalition worked with the practices, assessing needs and resources, teaching skills such as motivational interviewing, and handling all the management and reporting procedures for the care management teams. As time passed it became clear that the Coalition did not have the capacity to introduce quality improvement initiatives, and that there was friction between the Coalition-managed care teams and the practice staff. While they were able to demonstrate benefits of engagement with the two practices, the process and program itself was not sustainable and did not accomplish the Coalition's mission and vision for "big-picture, city-wide work."

Managed Care Contracts: Unifying Participation and Expectations

Just as the Bristol-Myers Squibb Foundation grant reached its halfway point, in December of 2013, the Coalition negotiated a large care management contract with United Healthcare. The contract was negotiated to provide care management services for its most complex patient population in the Camden region. Just over a year later, in January of 2015, the Coalition negotiated for a similar contract with Horizon New Jersey Health (an HMO that provided benefits for Medicaid enrollees). The expansive contracts forced a turning point within the CRI, as well as a push to get all the primary care practices encapsulated in the contract on board with the Coalition's program, culture, and expectations.

The Seven-Day Pledge: A New Approach

Reconnecting super-utilizers to primary care was a central focus of the Coalition. Looking back at their past success and failures, CRI decided to focus solely on the quality improvement aspect of their prior work with primary care practices and to simplify their goals. To that end, the two separate care management teams under the Bristol-Myers Squibb Foundation grant were absorbed into the general

clinical team, and CRI developed a common language and simple metric to approach the Camden primary care practices: the seven-day pledge.

As a much less costly form of health care, primary care played a crucial role in the Coalition's vision to bend the cost curve while improving quality of care. The Coalition believed that by reconnecting hospitalized patients to primary care, the providers could help prevent or stem unnecessary emergency department visits and other associated health care costs. Through the seven-day pledge and its associated components, the CRI department was trying to address and improve access to primary care for Camden's most vulnerable and costly patients. All of the workflows of the CRI revolved around the seven-day pledge within practices and the Camden community. They managed the patient and provider incentives, followed up with patients after discharge to elect or change primary care providers, managed and tracked provider visits, established scheduling champions at each practice, held community quality improvement dinners, and began an accessible monitoring and evaluation program for each practice.

As a metric, the seven-day pledge was both a way to stratify complex patients into a well-defined risk group and also a proxy for access to primary care. Developed with the P&PI department, CRI provided each practice with a monthly scorecard of all the Coalition's partner practices (see **Exhibit 21, Practice Scorecards**). The scorecards were presented internally at monthly meetings with each of the partners, and they functioned as a forum to talk about difficult cases and barriers. Alongside the monthly meetings, a provider champion, administrative champion, and frontline staff person (usually the scheduling champion) from each partner practice came together for a large quality improvement dinner. The gathering was an opportunity for all of the Camden practices to debrief, celebrate success, and receive further training on related topics like motivational interviewing or care methodologies. In both meetings, mediators were careful not to single out providers or practices, but rather encouraged the idea of a joint effort, partnership, and using outside resources. As a team member explained:

> You sort of start to trust that there are other resources in the community. Care management initiatives are starting to engage more and more of the most complex patients so that the focus of primary care can be shifted back towards its intent, which is to make sure that the health of the general population is being managed.

While the success rates at practices were rising, there was still a lot of work to do, according to Molly Cherington, the clinical manager of the Clinical Redesign Initiatives. She elaborated, "15 minutes— we can treat it like a scarce resource or we can really do something meaningful in 15 minutes… But it feels far away. We don't have nearly the behavioral health and addiction services here available in the city at all to be able to do that kind of work right now."

The CRI constantly navigated between future goals for care and access and the present constraints of the existing primary care in Camden. However, they recognized that the type of care most needed for this population was not yet available in the primary care setting, and the transformation necessary to achieve that level of care would be a time- and resource-intensive process.

<u>The Technical Assistance Program</u>

A team of seven, the Cross-site Learning and Workforce Development department coordinated many of the Coalition's educational activities, both internal and external to the organization. The technical assistance program, Brenner knew, would be the most challenged as they acquired new contracts in the coming months (see **Exhibit 22, Technical Assistance Sites**). The Coalition's technical assistance program

had four components: on-site kick-off/close-out meetings, monthly case conferences, topical webinars, and monthly program management calls. The kick-offs took a form similar to a press conference, where local stakeholders were invited to learn about the Coalition's work and the joint super-utilizer initiative. They were conducted in person and, according to one team member, they provided a platform to "kick off the relationship" between the organization, their stakeholders, and the Coalition.

At the monthly case conferences, sites presented a challenging patient case, explored best practices, and analyzed difficulties across the different sites. The topical webinars included lectures on some of the Coalition's core beliefs including harm reduction, trauma-informed care, motivational interviewing, and other topics to improve patient relationships and outcomes. The final component was program management calls, which were upper-level discussions between Brenner and the organization leadership. During these calls, Brenner helped the organizations plan for sustainability, work through institutional issues and mediate barriers with local stakeholders.

The Coalition charged the technical assistance organizations a flat rate of $50,000, which remained a "fairly set, off-the-shelf offering" according to one team member. This format presented challenges for whole department. Each site that contracted with the Coalition had its own specific geography, culture, goals and intervention. The range of needs across the sites differed immensely; in order to be successful, the technical assistance program needed to have a certain measure of specificity for each site, but not so much as to have to grow the overall size of the team for every new contract. In order to avoid growing exponentially, striking a balance between acquiring new sites, specificity, and team growth would be critical. At the same time, however, the sites themselves wanted some amount of customization, and in particular, price control. As a team member elaborated:

> People are looking for, for lack of a better term, more of a Dell-model, where they want to pick and choose the pieces that they want to add to their contract, and pay less or pay more based on exactly the specifications that they want…. So, finding something that we can deliver effectively that is also attractive to a wider audience of people while reaching as many sites across the country as possible has been a challenge of expansion that we're working through.

Brenner and the leadership recognized that the demand for the technical assistance program was growing as the Coalition continued to gain acclaim, and Coalition fielded phone calls from interested organizations almost daily. However, the leadership also knew that the cost and relative rigidity of the technical assistance model had been prohibitive to some interested organizations. Many organizations craved both customization and cost control. As the program continued to look for contracts and sustainability, they were also navigating the natural limits of a small team.

Conclusion: to Buy or to Build

Reflecting on the past ELT meetings in his office, Brenner recalled some very intense conversations about the implications of the lack of service funding: not only would it be a huge risk financially, but a poorly delivered program could be harmful to patients. He certainly knew that other nonprofits in the area had purposefully not responded to requests for proposals if the service dollars were not high enough, but the Coalition was not like other nonprofits. Though they didn't have enough grant funding currently to cover the voucher program, they might be able to fundraise and negotiate funding from other sources. In Brenner's experience, "a lot of funding cycles are year by year and you always look like you're going off a cliff and looking at the cliff and noodling about it is a total waste of time." Yet, even apart from the risks,

there were other existential questions as well: what business did the Coalition have entering the housing sphere? The Coalition already had a complex portfolio of activities; if they added a whole other field to their work, Terranova asked, "how do we brand ourselves so that people understand?" Furthermore, the Coalition already had partners in housing — even if those partners followed a continuum of care approach, was it really up to the Coalition, Brenner wondered, to "push this over the edge?"

And then, if they did accept the vouchers, how would they operationalize a voucher program? Brenner knew that it ultimately came down to capacity. As the leadership team understood it, they had three options for delivery: they could deliver the service themselves, they could hire someone from outside with no ties to the community to deliver the service, or they could work with their local partners to deliver the service. Each option had both pros and cons. If they delivered the service themselves they could guarantee access for their patients and would have more control over the entire process. However, they would also risk alienating their local partners, and as Susco noted, "there's a limit to the number of organizational capabilities that we can actually do... [This is] a whole other set of capabilities that would be necessary to be a Housing First provider… This could eclipse a lot of other things we are trying to do and would require so much effort and energy."

Humowiecki noted that the benefits of bringing in an outsider were precision and experience. "We want this done right," he had said, "we could go out and spend money to hire people who have done this before and do it right." Yet, as Craig had pointed out, if they went out and hired someone, how could the Coalition guarantee access for their patients, who had been so systematically refused before? "Any time you're working with someone else, you lose a little bit of control," she had noted.

If instead they chose to partner with their pre-existing partners, Brenner knew it would continue to strengthen the Coalition's presence and help build capacity within the city. However, the partners were philosophically divided from the Housing First model, and Brenner knew it would be tough to secure their cooperation, and even tougher to ensure fidelity to the model. In order to implement Housing First, Brenner believed their partners would need to "rethink what they are doing, how they structure their services, how they train their staff...Reassess big things, like theories of change, that have grown obsolete over time." He believed that route would be a long journey.

Faced with multiple decisions and no clear answers Brenner stood to stretch his legs. As he absent-mindedly scanned the office walls, his eyes caught a poster of the Coalition's core values. Given their history and experiences, their successes and failures, their mission and values, he wondered, should they take it on? And if so, how should they proceed?

APPENDIX

Exhibit 1: Grants Awarded to the Coalition

February 2009	Merck Foundation (Building a Citywide DM Collaborative)	$2,000,000
November 2010	State of New Jersey and Federal Government ARRA	$1,000,000
July 2010	Nicholson Foundation (Building Capacity of the Coalition)	$327,000
August, 2011	Bristol-Myers Squibb Foundation (Together on Diabetes)	$3,450,336
December 2011	Robert Wood Johnson Foundation (Aligning Forces 4 Quality)	$900,000
September 2012	Commonwealth Fund	$254,472
Payment Period 2012-2014	Nicholson Foundation (Safety-Net Accountable Care Organization)	$660,932
July 2012	Centers for Medicare and Medicaid Innovation (Linked to Care)	$2,788,457
Payment Period 2013-2014	Nicholson Foundation (Medicaid ACOs in Camden)	$1,168,200
January 2014	Bristol-Myers Squibb Foundation	$100,000

Source: Compiled by Case Writer from:

Alliance to Reduce Disparities in Diabetes, "Camden Citywide Diabetes Collaborative," Alliance to Reduce Disparities in Diabetes Informational Website, https://www.merck.com/corporate-responsibility/docs/access/GranteesFACTSHEET.pdf, accessed July 2015.

Bristol-Myers Squibb Foundation, "Together on Diabetes: Camden Coalition of Healthcare Providers," Bristol-Myers Squibb Foundation Website, http://www.bms.com/togetherondiabetes/partners/Pages/camden-coalition-healthcare-providers.aspx, accessed July 2015.

Centers for Medicare & Medicaid Services, "Health Care Innovation Awards: New Jersey," CMS.Gov Website, https://innovation.cms.gov/initiatives/health-care-innovation-awards/new-jersey.html, accessed July 2015.

Nicholson Foundation, "What we do: Projects," Nicholson Foundation Website, https://thenicholsonfoundation.org/what-we-do/projects, accessed July 2015.

ProPublica, "Camden County, N.J., funds by the Department of Health and Human Services," ProPublica Website, https://projects.propublica.org/recovery/locale/new-jersey/camden/dept/7500, accessed January 2016.

The Commonwealth Fund, "Spreading Use of a Health Care 'Hotspotting' Tool to Improve Quality and Reduce Costs," The Commonwealth Fund Grants and Fellowships Website, http://www.commonwealthfund.org/grants-and-fellowships/grants/2012/jul/spreading-use-of-a-health-care-hotspotting-tool, accessed July 2015.

Exhibit 2: Mission, Vision, and Values of the Coalition

About the Camden Coalition

Better care at lower costs

As a coalition of Camden health care providers, community partners, and advocates, we are committed to elevating the health of patients facing the most complex medical and social challenges.

We are a non-profit organization working in the community to improve health and reduce costs. We innovate and test health care delivery models to improve patient outcomes and reduce the cost of their care using data driven, human-centered practices. Drawing on the experiences of our clinical team and patients, Coalition staff also work to transform health care cost and delivery at the policy level.

With over a decade of experience working with vulnerable populations in the city, we share our learning with other communities across the nation to help them implement our philosophies and methods.

Mission

Our mission is to improve the health status of all Camden residents, by increasing the capacity, quality, and access of care in the city.

Vision

Camden will be the first city in the country to bend the cost curve while improving quality.

Core Values

Servant Leadership
We strive to serve as compassionate servant leaders, allowing us to focus on the growth and well being of the individuals and the community we serve. We aim to empower our patients, members, and partner organizations to improve performance every day.

Communication and Collaboration
We believe that open, honest, and consistent communication within our staff and with our community, members, and partners allows for collaboration and expands the support and investment in our mission. We are committed to being open source and sharing our knowledge with others so that we ultimately integrate our model and priorities into the broader healthcare system.

Compassion and Respect
We respect our patients, our members, and our community. We respect the different needs, backgrounds, and life experiences of all those we encounter and through compassion for each individual's unique experience, we strive to serve and engage them in our mission.

Innovation
We strive to innovate by strategizing and reworking solutions to meet the needs of patients in our community. We understand that with innovation comes the risk of failure; however, we embrace the learning opportunities that continuously inform our work. We understand that success in our work requires changing systems from office practice to state and national policies.

Data Driven
We use data to guide our discussions and decisions, to evaluate program progress, and to guide program improvements.

Source: Camden Coalition of Healthcare Providers, Camden Coalition of Healthcare Providers Website, "About the Coalition," Camdenhealth.org/about/about-the-coalition/history/, accessed March 2015.

Exhibit 3: Selected Demographics of Camden, New Jersey

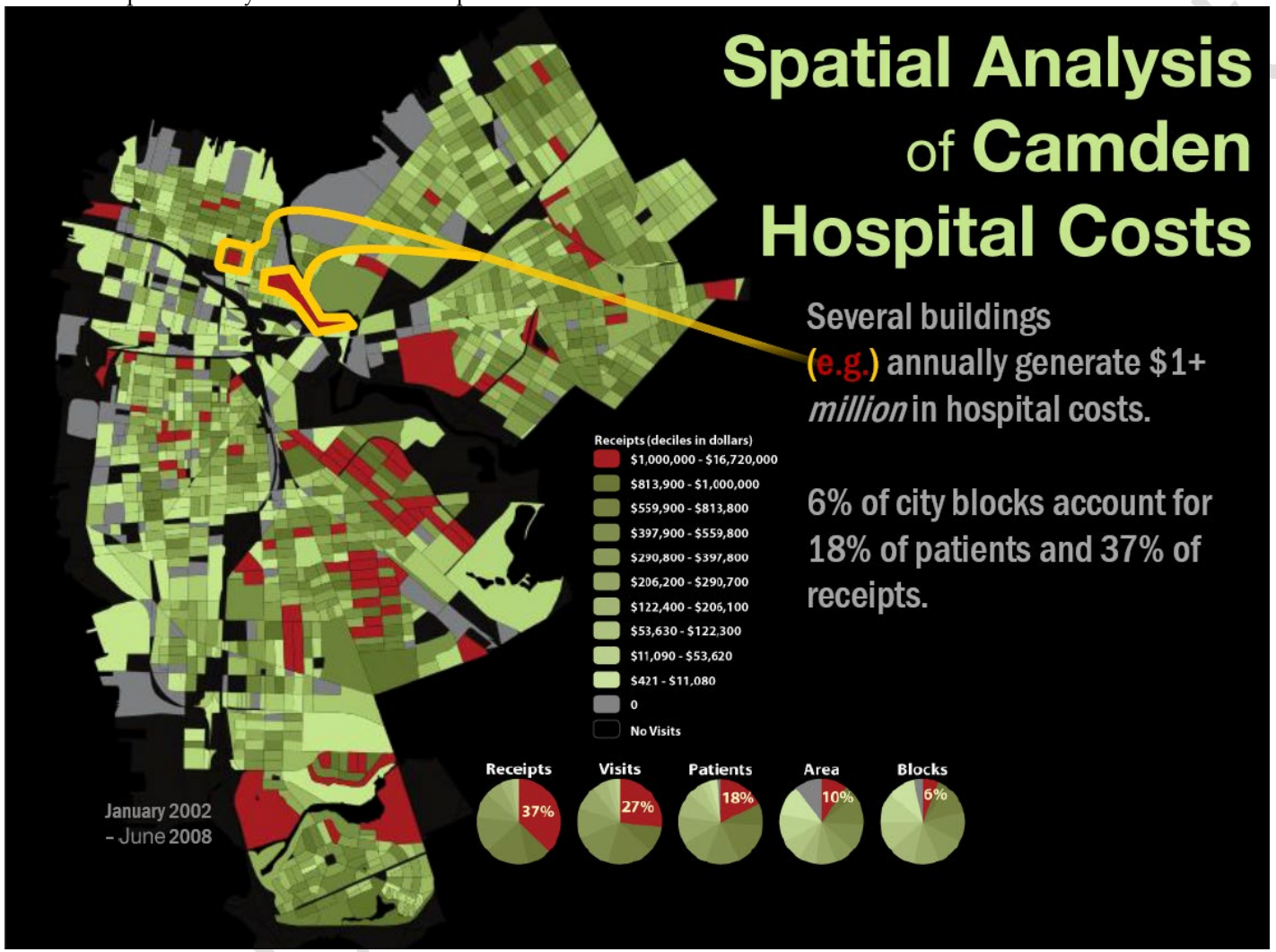
Household Demographics	**Camden**		**New Jersey**	
	Count	*Percentage*	*Count*	*Percentage*
Households with one or more people under 18 years	10,727	42.8%	1,104,442	34.7%
Households with one or more people over 65 years	4,980	19.9%	867,372	27.2%
Number of unmarried* women 15-50 years old who had a birth in the past 12 months	1,271	80.2%	32,509	29.6%
Number of grandparents responsible for grandchildren	1,100	46.5%	46,781	26.2%
Median household income	$26,202	X	$71,629	X
Median family income	$29,644	X	$87,347	X
Median nonfamily income	$15,303	X	$39,789	X
English only spoken at home	39,515	56.1%	5,804,858	70.0%
Language other than English at home	30,968	43.9%	2,489,641	30.0%
Speak English less than "very well"	14,576	20.7%	1,026,943	12.4%
Spanish spoken at home	28,564	40.5%	1,277,011	15.4%
Speak English less than "very well"	13,297	18.9%	593,496	7.2%
Employment	**Camden**		**New Jersey**	
Population 16 years and over	*Count*	*Percentage*	*Count*	*Percentage*
Unemployed	7,762	13.9%	472,094	6.7%
Not in labor force	23,886	42.8%	2,351,129	33.4%
All families with income below federal poverty level in past 12 months	36.0%	X	7.9%	X
All people	39.8%	X	10.4%	X
Under 18 years	54.0%	X	14.9%	X
18 years and over	33.2%	X	9.0%	X
18 to 64 years	33.9%	X	9.3%	X
65 years and over	27.6%	X	7.8%	X
Educational Attainment	**Camden**		**New Jersey**	
Population 25 and over	*Count*	*Percentage*	*Count*	*Percentage*
Less than 9th grade	6,177	14.1%	327,689	5.5%
9th to 12th grade, no diploma	8,744	20.0%	385,198	6.4%
High school graduate (or equivalency)	16,037	36.7%	1,743,628	29.0%
Some college, no degree	7,919	18.1%	1,024,284	17.0%
Associate's degree	1,533	3.5%	375,299	6.2%
Bachelor's degree	2,611	6.0%	1,336,219	22.2%
Graduate or professional degree	721	1.6%	815,429	13.6%
Percent bachelor's degree or higher	X	7.6%	X	35.8%

Exhibit 3 Continued: Selected Demographics of Camden, New Jersey

Health & Insurance	**Camden**		**New Jersey**	
	Count	*Percentage*	*Count*	*Percentage*
Under 18 with a disability	1,744	7.3%	73,070	3.6%
Aged 18 to 64 with a disability	7,866	17.4%	416,429	7.6%
Over 65 with a disability	2,823	47.0%	391,830	33.1%
Health Insurance Coverage	58,994	78.5%	7,603,415	87.2%
Public health insurance coverage	39,852	53.0%	2,264,163	26.0%
No Health Insurance Coverage	16,167	21.5%	1,119,796	12.8%

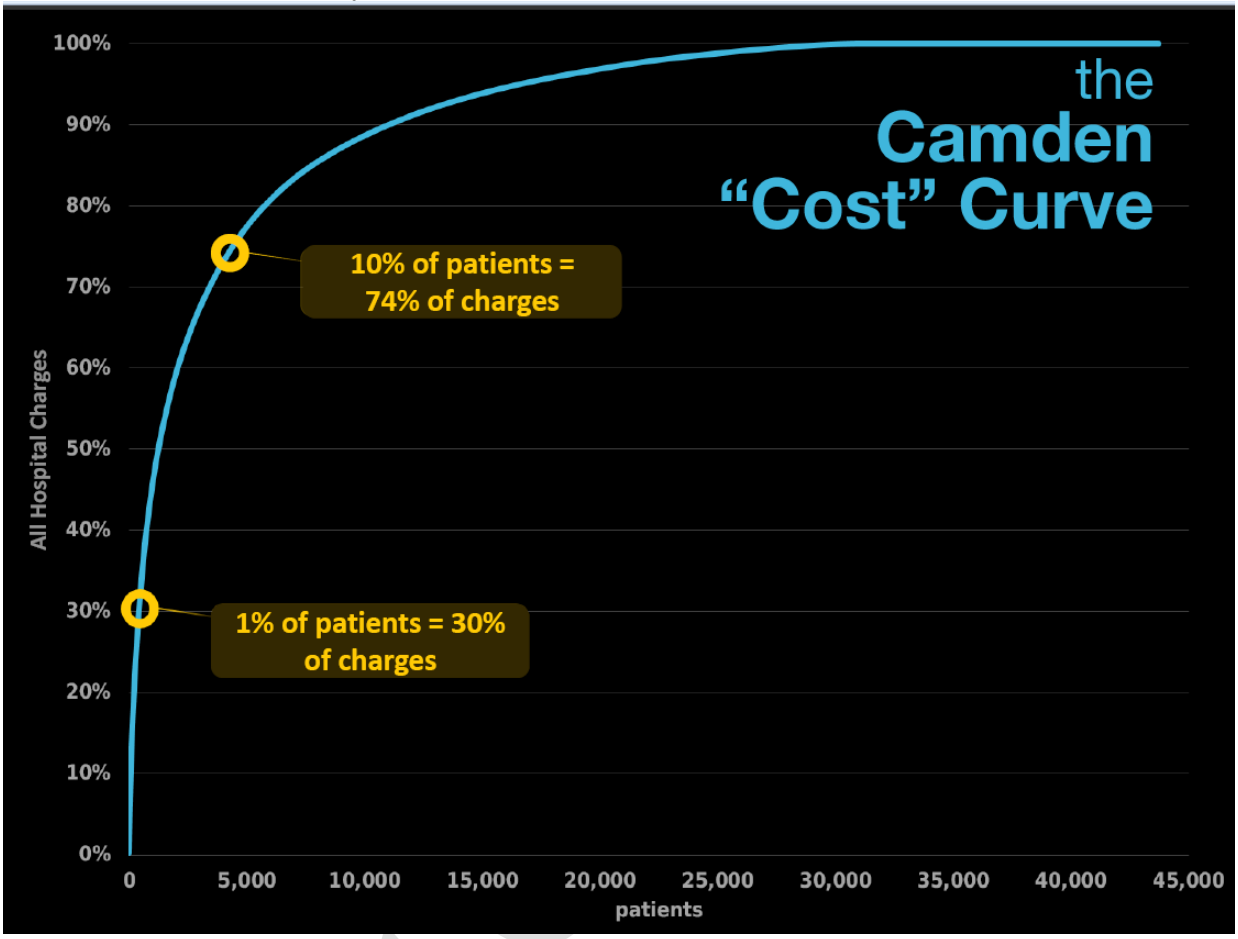
Source: Data from 2013 American Community Survey Population Estimates, U.S. Census Bureau, U.S. Department of Commerce, available at http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml, accessed April 2015.

Exhibit 4: Spatial Analysis of Camden Hospital Costs



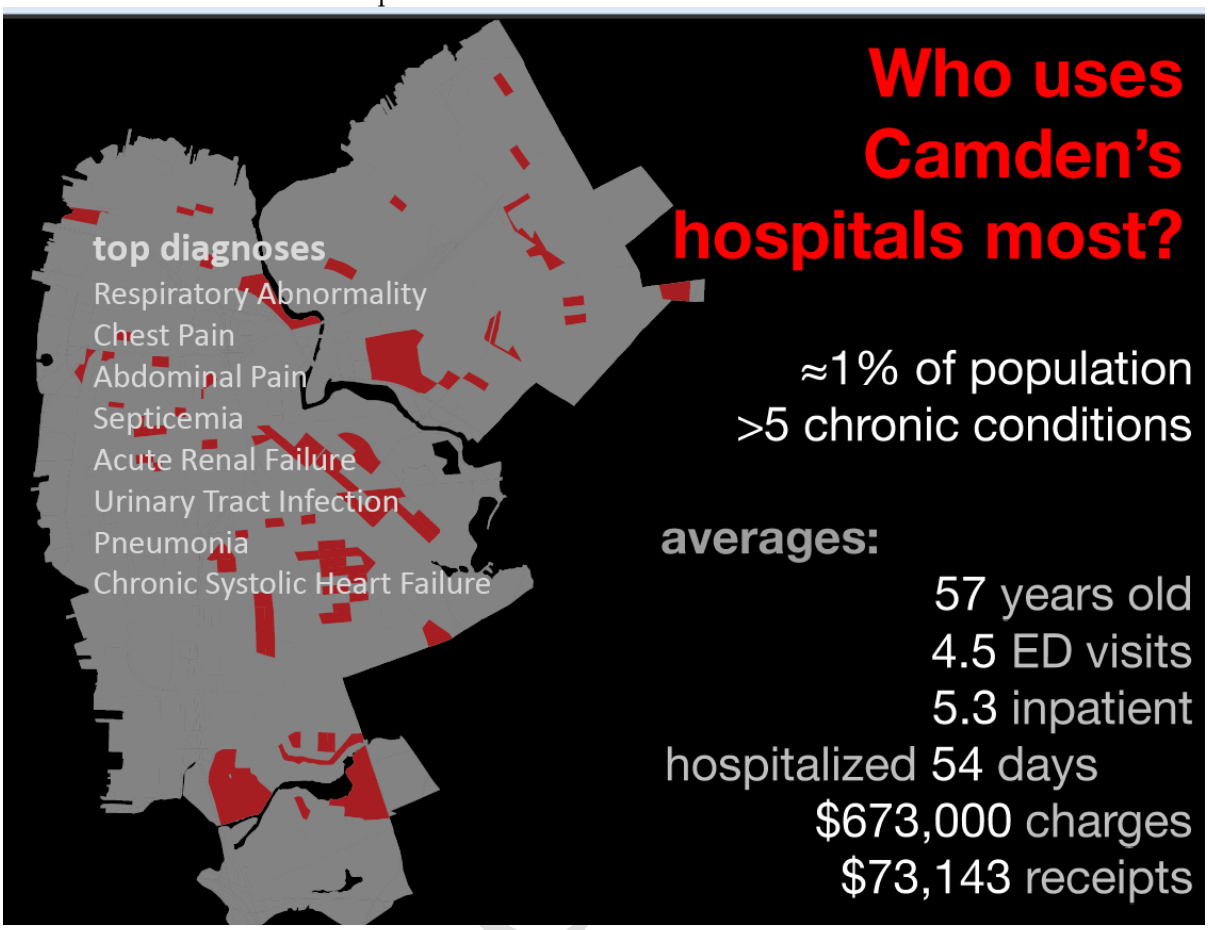
Source: Stephen Singer, "Open House: Data & Evaluation Presentation," PowerPoint Presentation, June 10, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 5: Camden New Jersey Cost Curve



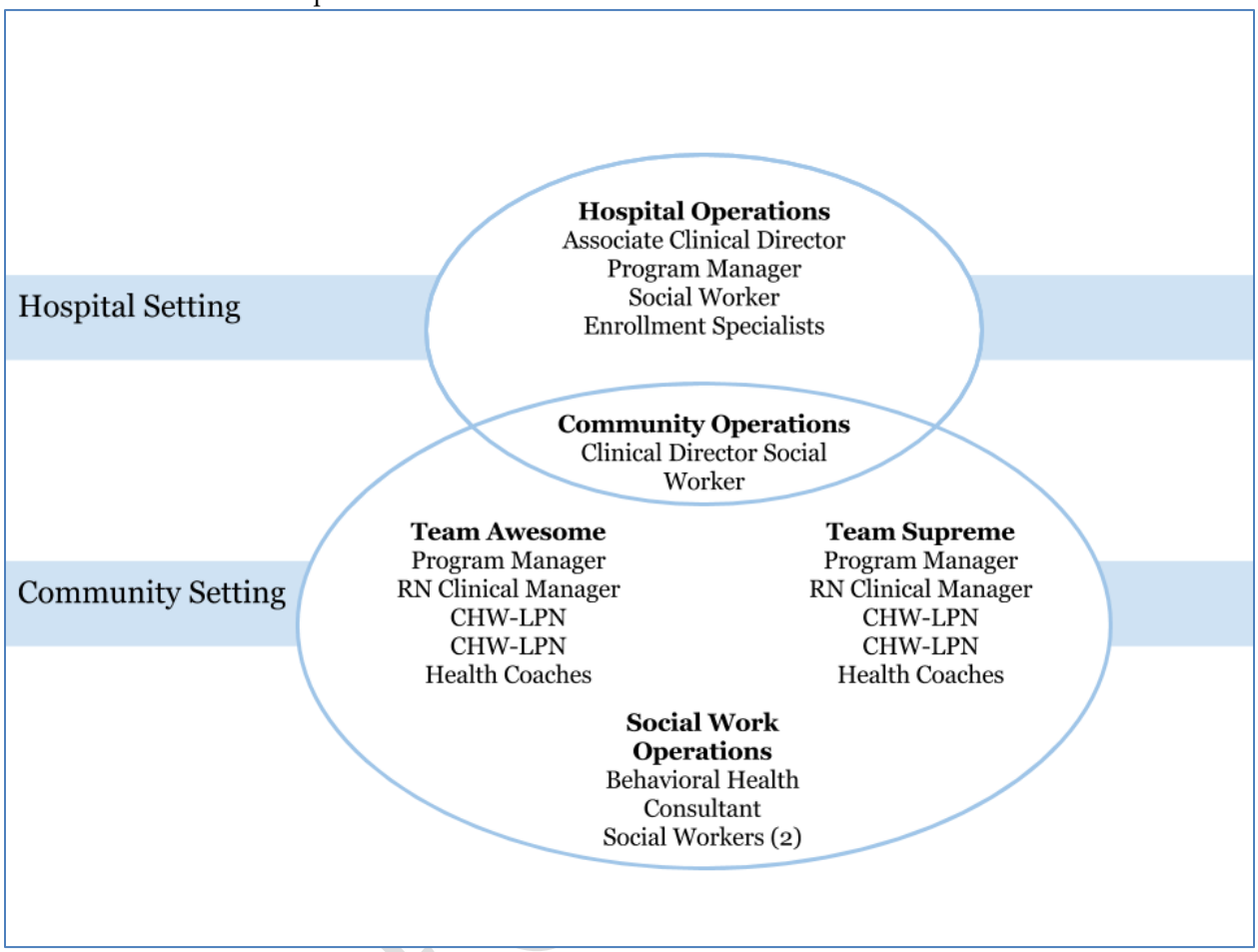
Source: Jeffrey Brenner, "Open House: Introduction," PowerPoint Presentation, June 10, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 6: Camden Profile of Super-utilizers



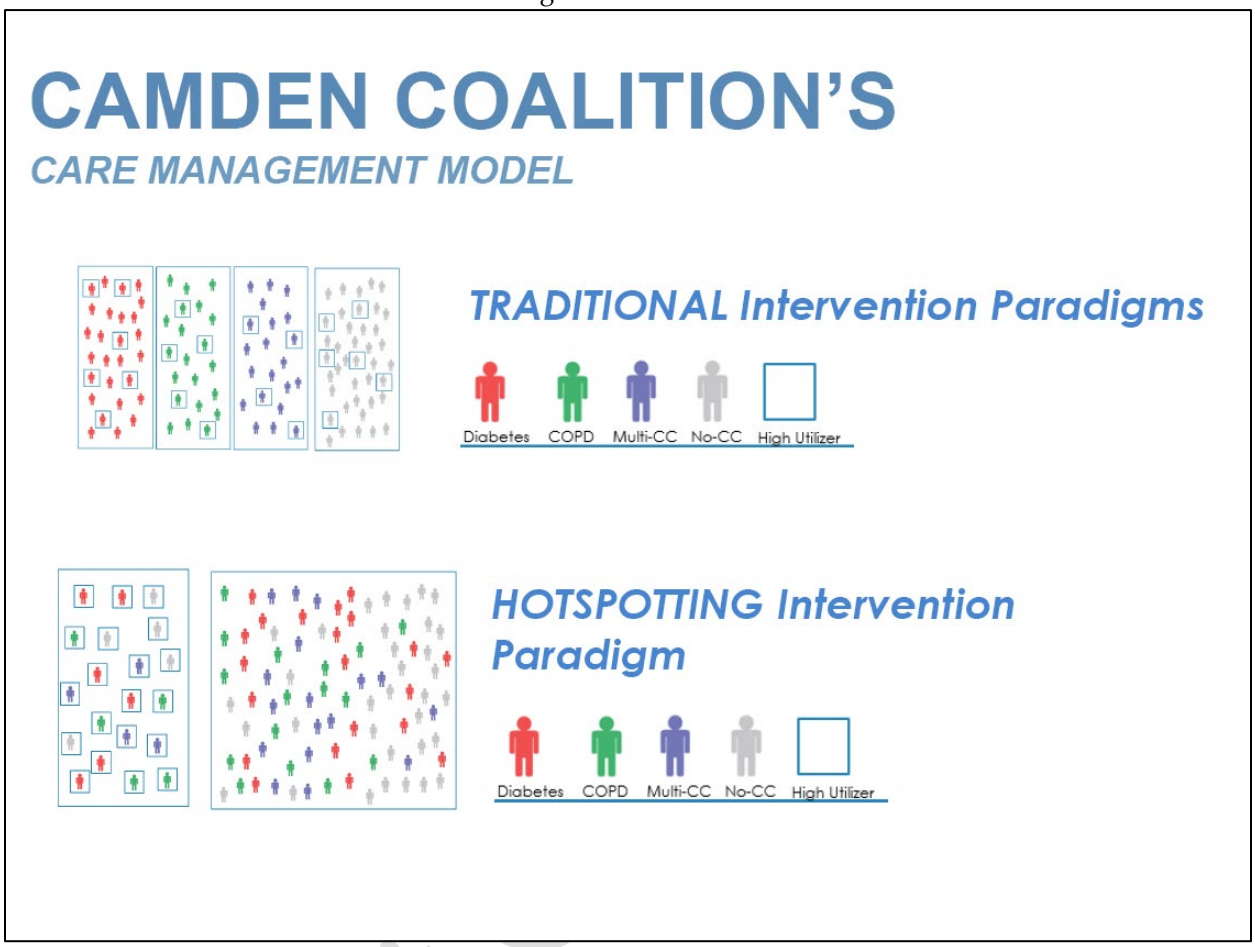
Source: Stephen Singer, "Open House: Data & Evaluation Presentation," PowerPoint Presentation, June 10, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 7: CMI Team Composition



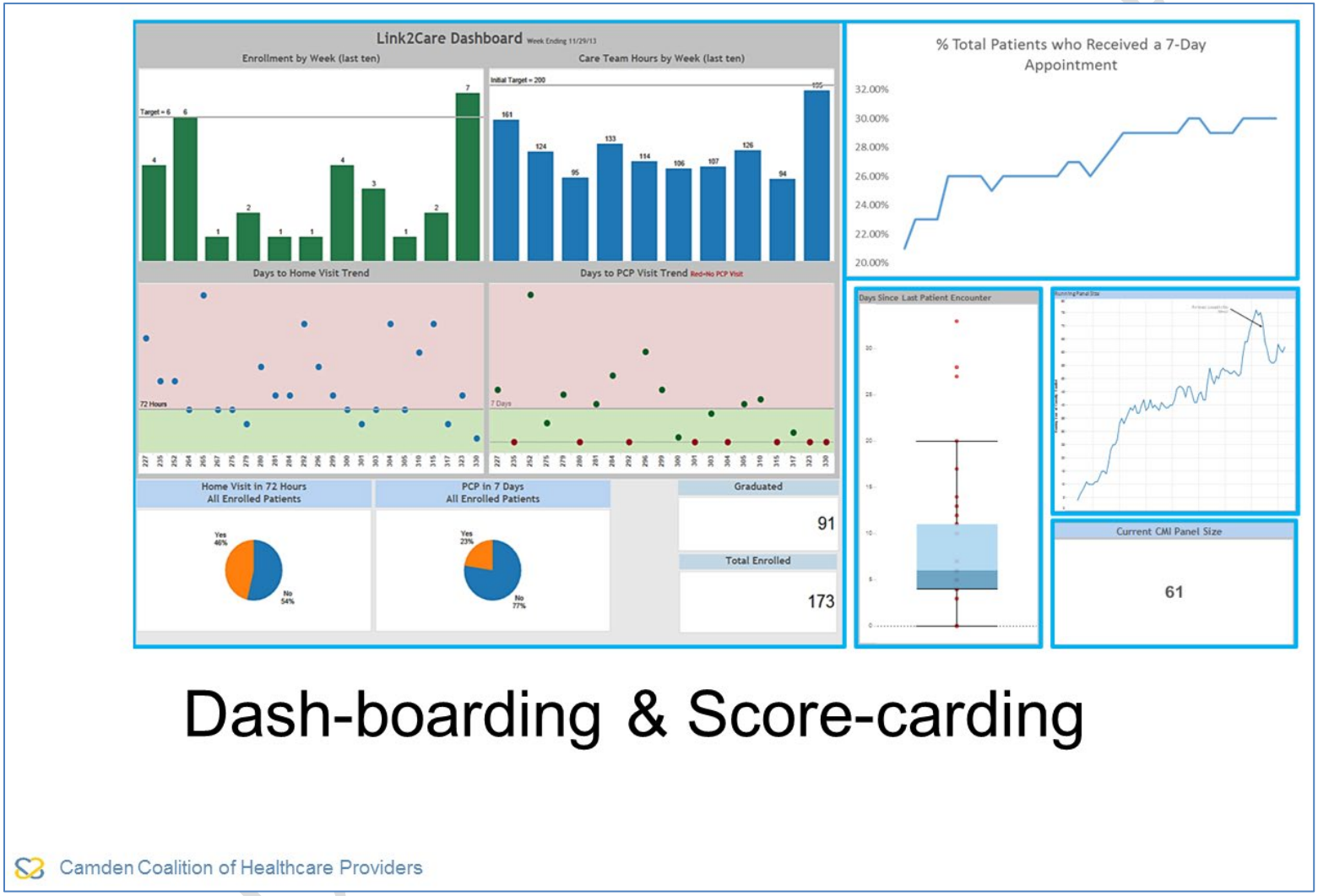
Source: Compiled by Case Writer from Jason Turi, "Open House: Basics of the Coalition's CMI," PowerPoint Presentation, June 10, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 8: The Coalition's Intervention Paradigm



Source: Kelly Craig, "Hot Spotting 101," PowerPoint Presentation, June 9, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 9: TrackVia Screenshot & Score Card



Source: Margaret Hawthorne, "Open House: Hot Spotting and Tracking," PowerPoint Presentation, June 10, 2015. Camden Coalition of Healthcare Providers, Camden, NJ.

Exhibit 10: HHRP Partners

Partners and Coordination of Services

The success of this effort will depend on the strength of this partnership, coordination of effort and timely communication. CSP-NJ and the Camden HealthCare Coalition will collaborate around the collection and sharing of patient/tenant data; identification of referrals; assessment and screening; and coordination of delivery of health care services, including linkage to a primary care provider; and follow-up to determine individual's wellness and stability in housing.

CSP-NJ – Supportive Housing and Recovery and Wellness Provider

CSP-NJ will assist the Camden Coalition of Healthcare Providers (CCHP) with assessment, referrals and outreach to potential participants. Assessment and outreach will be provided by a team to provide continuity and coordination of effort. CSP-NJ will also work with CPAC to assist participants with application, documentation and securing rental assistance and housing. CSP-NJ will assist individual's with housing search, leasing and obtaining documentation, security deposits and household items. CSP-NJ will assist with transportation to primary care and mental health services and appointments as needed. Further CSP-NJ will provide participants with a full range of wellness oriented supportive services to enhance participant's capacity to set and follow health habits and routines conducive for well-being.

Camden Coalition of Healthcare Providers (CCHP), Health Care Provider

The CCHP will provide coordinated health care for participants for a period of up to 9 months, then the individual will be followed by CSP-NJ in coordination with an established primary health care provider. At the end of this period the participants should be fully linked to a primary health care provider with follow up and housing provided by CSP-NJ. During the 18 month period, CCHP staff will work with CSP-NJ to identify targeted participants; assist with outreach and connection to CSP-NJ services; and coordinate access and provision of health care services. CCHP will work with participants to link them to a primary health care provider who can follow them long-term. CSP-NJ will assist with this process as needed and provide follow up with the participants and their primary care provider's long term.

Community Planning and Advocacy Council (CPAC), Housing Provider

CPAC will provide HUD Shelter plus housing rental assistance vouchers or other available rental assistance for selected participants.

United Way of Atlantic County (AC)

The United Way of AC will assist the HHR Pilot with access to community resources for household furnishings and other available resources as needed.

Pilot Review Committee

A review committee will meet every two months for the first year to monitor implementation, identify barriers and issues and to track outcomes and project effectiveness. After the first year, depending on need, these meetings may be scheduled on a bi-monthly or quarterly basis. Membership on the committee will be comprised of representatives from the Partner organizations and other individuals selected by the partner organizations as appropriate.

Source: Camden Coalition of Healthcare Providers, Camden Home Health Recovery Pilot (Camden, NJ: September 2012), p. 8-9.

Exhibit 11: Processes and Roles of HHRP

- Potential participants will be identified by the Coalition and Referral to CSP-NJ .
- The Coalition will determine eligibility and will conduct pre-screening for housing eligibility including determination of 1) homeless status, 2) disability status, 3) criminal background regarding assault, sexual assault, or drug possession or distribution over the past 3 years (criteria that could exempt persons from eligibility for HUD Shelter Plus Care vouchers); and determination if individuals have birth certificates, picture ID and social security number for housing applications.
- The Coalition and CSP-NJ staff will meet together to outreach individual, and continue to work together to engage with the goal of engaging in CSP-NJ housing and supportive housing and recovery and wellness services.
- CSP-NJ HHRP staff will work with the individual to rapidly house as soon as possible – within 30 days.
- CSP-NJ HHRP staff will continue to confirm housing eligibility for shelter plus voucher, obtaining criminal background check and documents needed for housing rental assistance applications and housing search. If the individual is not eligible for traditional housing or vouchers, staff will assess what other options are available with the goal of securing a voucher and enter into housing search
- CSP-NJ HHRP Staff continues to meet 2-3 times a week to continue to engage and secure necessary documents, linking to HHRP team and CSP-NJ self-help center and another community resources,
- CSP-NJ HHRP staff will locate sources for household furnishings and other resources for move in phase
- CSP-NJ HHRP staff will work with CPAC and assist with housing search and applications for housing
- Staff will collaborate with the Coalition staff and participants to engage and support on health and medical goals and follow up, and link to primary care providers for on-going medical care and follow up.
- CSPNJ staff will assertively engage and support on practical tasks related to medical follow up and work to initiate and continue to engage with primary care providers
- CSPNJ staff will continue to engage and provide support for wellness efforts including but not limited to smoking cessation, sobriety, improved diet and nutrition, linkage to mental health and substance abuse treatment and self-help groups, pursuit of employment and education goals and goals in other recovery and wellness domains

Source: Compiled from Camden Coalition of Healthcare Providers, Camden Home Health Recovery Pilot (Camden, NJ: September 2012), p. 7-8.

Exhibit 12: Details on Section 8 Housing Vouchers

The Housing Choice Voucher Program (Section 8) is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

A housing subsidy is paid to the landlord directly by the public housing agency (PHA) on behalf of the participant or family. The participants then pay the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a participant may use its voucher to purchase a modest home. The PHA calculates the maximum amount of housing assistance allowable. The maximum housing assistance is generally the lesser of the payment standard minus 30% of the family's monthly-adjusted income or the gross rent for the unit minus 30% of monthly-adjusted income.

Eligibility for a housing voucher is determined by the PHA based on the total annual gross income and family size and is limited to U.S. citizens and specified categories of non-citizens who have eligible immigration status. In general, income may not exceed 50% of the median income for the county or metropolitan area in which the family/individual chooses to live. By law, a PHA must provide 75 percent of its voucher to applicants whose incomes do not exceed 30 percent of the area median income. Median income levels are published by HUD and vary by location.

To cover the cost of the program, the U.S. Department of Housing and Urban Development (HUD) provides funds to allow PHAs to make housing assistance payments on behalf of the families. HUD also pays the PHA a fee for the costs of administering the program. When additional funds become available to assist new families, HUD invites PHAs to submit applications for funds for additional housing vouchers. Applications are then reviewed and funds awarded to the selected PHAs on a competitive basis. HUD monitors PHA administration of the program to ensure program rules are properly followed.

Source: Compiled from U.S. Department of Housing and Urban Development," Housing Choice Voucher Program (Section 8)," HUD portal, http://portal.hud.gov/hudportal/HUD?src=/topics/housing_choice_voucher_program_section_8, accessed May 2016.

Exhibit 13: Camden Coalition of Healthcare Providers Statement of Revenue and Expenditures 3 Months April 1, 2015 to June 1, 2015

	Apr-15	May-15	June -15
Revenue			
Pledges and Contributions	9,742	7,473	28,797
Grants	340,471	661,213	549,571
Contracts	50,000	60,416	44,166
Technical Asst Inc	20,833	20,833	20,833
Membership Dues	22,083	22,083	21,883
Other Income	33,571	40,434	76,470
Total Revenue	476,700	812,452	741,720
Expenditures			
Salaries	298,626	303,777	316,624
Payroll Taxes	30,456	29,858	29,491
Employee Benefits	51,673	30,956	51,612
Mgmt & Contracted Services	54,462	100,377	76,002
Professional Fees	21,725	26,902	28,826
Rent	19,169	19,169	19,169
Office Expense	1,112	1,881	2,503
Other Fees	2,443	7,102	13,698
Utilities	2,270	3,235	3,622
Insurance	3,168	7,158	3,453
Printing copying	2,870	3,703	3,454
Dues Fees and Licenses	83	0	647
Travel	10,987	7,003	8,811
Food/Catering	2,706	4,661	6,553
Software/Equip - Maint	41,477	40,247	55,526
Depreciation	1,901	1,901	1,901
Outside Training	147	18,846	10,243
Patient Costs	4,429	6,622	8,601
Administration	41,433	50,124	48,834
Other Direct Expense	50,251	9,435	771
Total Expenditures	641,388	672,957	690,341
Net Revenue Over Expenditures	(164,688)	139,495	51,379

Source: Compiled from Jared Susco & Sheila Brown, "Question on financials for A Case Saturday," e-mail message and documents to Sophia Arabadjis, June 9, 2016.

Exhibit 14: ELT Members and Responsibilities

Kelly Craig is the Senior Director, Care Management Initiatives and supports the design, development, and expansion of the care management initiative. Kelly oversees the program's objectives to improve health care access to medically and socially complex patients in Camden while also working to reduce health care costs. She is committed to improving health care quality and accessibility for all individuals, especially vulnerable populations. Kelly's academic background includes studies in addictions, health, and mental health with a community and policy focus. She received her master's degree in social work from Temple University and undergraduate degree in social work from the University of Central Florida.

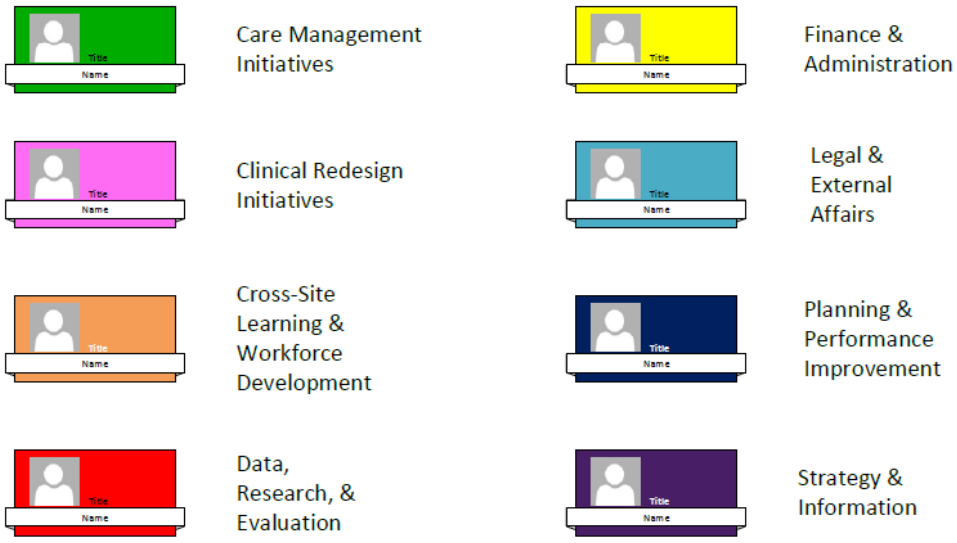
Mark Humowiecki is the Coalition's General Counsel and Director of External Affairs. He leads all local, state and national advocacy efforts. Prior to joining the Coalition, Mark served as Deputy Executive Director of the New York Workers' Compensation Board, where he led transformational efforts to improve the administration of workers' compensation benefits. Before his work in government, Mark spent six years as an employment attorney for the Legal Aid Society and in private practice in New York City. Mark is a graduate of Yale College and Yale Law School.

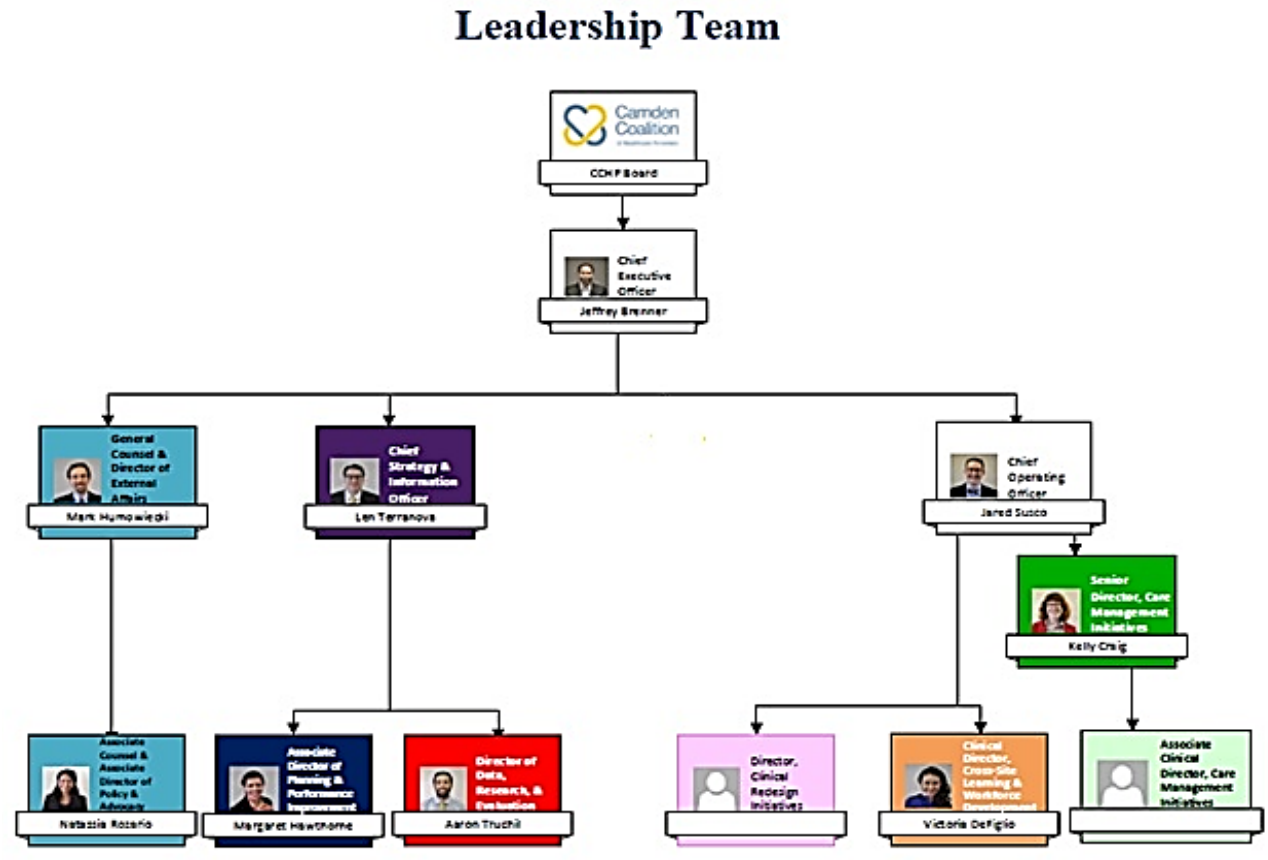
Jared Susco is the chief operating officer of the Camden Coalition, where he brings business principles, like continuous improvement, systems thinking, and project planning, to the effective and efficient execution of the mission. Jared's focus is largely internal, with emphasis on deepening structure, metrics, process, analysis, and planning for CCHP's existing programs and on supporting outcome- and performance-driven teams with mentoring, coaching, coordination, and integration. Prior to joining CCHP, Jared served as the chief financial officer for Penn Dental Medicine, as the director of administration and planning for the Wharton Undergraduate Division, and as a brand manager for the Campbell Soup Company. Jared holds an MBA from Emory University and a BS in Economics from the University of Pennsylvania.

Len Terranova is the Chief Strategy & Information Officer at the Camden Coalition of Healthcare Providers Coalition. He oversees strategic planning, performance improvement, research and development, and fundraising, working with a broad range of stakeholders to leverage business best practices for enduring social good. Len has and MBA from Temple University's Fox School of Business and has done post-graduate work in Applied Statistics at Penn State. Len has experience in operations management, quantitative and qualitative data analysis, and process improvement in both the public and private sector. Before joining the coalition he worked as an executive in the hospitality industry, as a consultant for The School District of Philadelphia, and as an operational excellence/Six Sigma consultant in the pharmaceutical industry.

Source: Camden Coalition of Healthcare Providers, "Meet Our Staff," Camden Coalition of Healthcare Providers Website, https://www.camdenhealth.org/about/meet-our-staff/, access May 2016.

Exhibit 15: Organizational Chart





Source: Jared Susco, "Organization Chart 2015," e-mail message and documents to Sophia Arabadjis, June 17, 2015.

Exhibit 16: Chapter 114

1. Increase access to primary care, behavioral health care, pharmaceuticals and dental care by Medicaid recipients residing in defined geographic regions
2. Improve health outcomes and quality as measured by objective metrics and patient experience of care
3. Reduce unnecessary and inefficient care without interfering with patients' access to their health care providers or providers' access to existing Medicaid reimbursement systems
4. Reduce the inappropriate use of high-cost emergency care by both Medicaid recipients and others, especially where an individual's need is more properly addressed through non-emergency primary care treatment
5. Develop relationships with primary care, behavioral health, dental, pharmacy and other health care providers to develop strategies to
    a. Engage these individuals [high utilizers] in treatment
    b. Promote medication adherence, management, and healthy lifestyles
    c. Develop skills in help-seeking behaviors including self-management and illness management
    d. Improve access to services for primary care and behavioral health care needs through home-based services, telephonic and web-based communication, via culturally and linguistically appropriate means
    e. Improve service coordination to ensure integrated care for primary care, behavioral health care, dental care, and other health care needs, including prescription drugs

Source: Compiled from New Jersey State Congress, P.L. 2011. *Chapter 114, Medicaid ACO Demonstration Project* (August 18, 2011), C.30:4D-8.1 (http://www.njleg.state.nj.us/2010/Bills/PL11/114_.PDF)

Exhibit 17: Partners of the Coalition
Starred (*) partners indicate encapsulation in ACO gainsharing.

Hospitals
- Cooper Health System*
- Lourdes Health System*
- Virtua*

Primary Care Providers
- Dr. Ramon Acosta*
- CAMcare Health Corporation*
- Fairview Village Family Practices*
- Project H.O.P.E.*
- Reliance Medical Group*
- St. Luke's Catholic Medical Services*

Behavioral Health Organizations
- Collaborative Support Programs of New Jersey
- South Jersey Behavioral Health Resources
- Twin Oaks Community Services
- Volunteers of America Delaware Valley

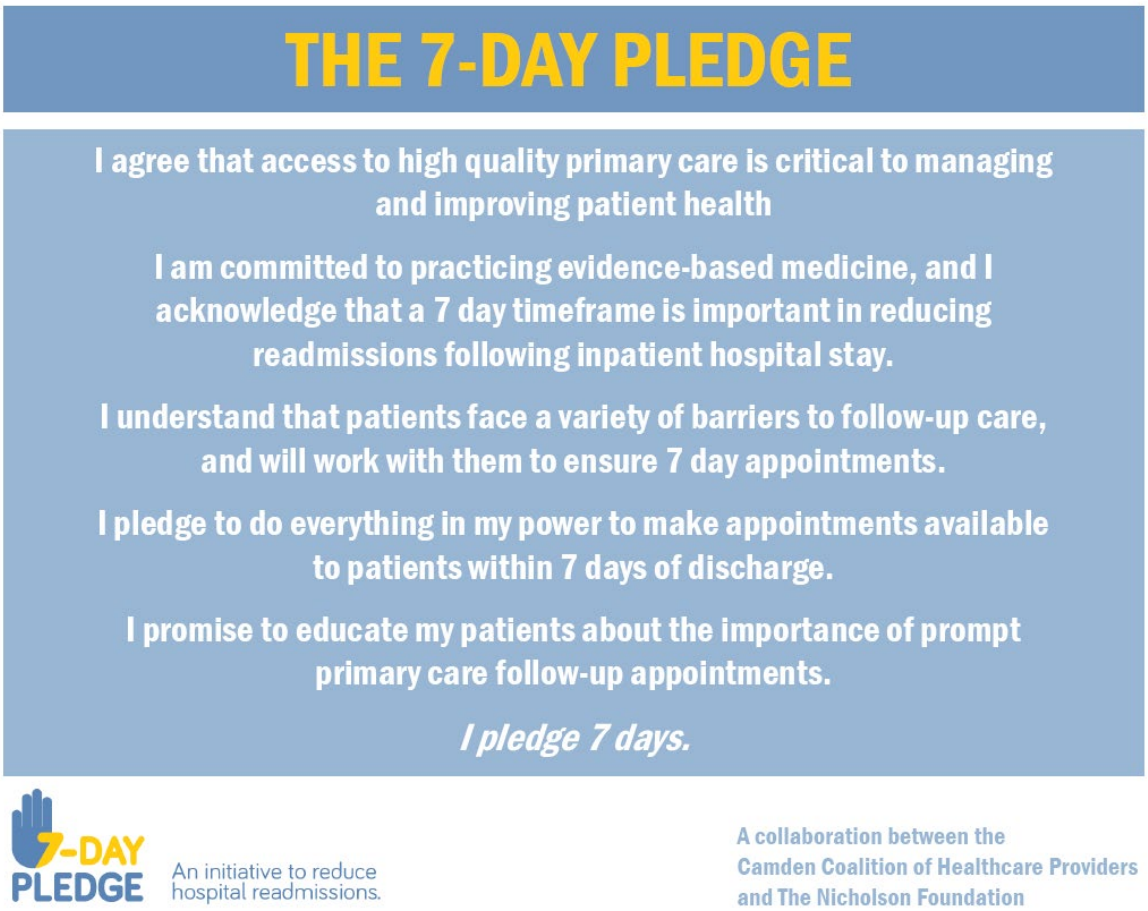
Resident/Community Organizations
- AARP
- Camden Churches Organized for People
- Northgate II Residents' Advisory Board

Health Plans
- Horizon NJ Health*
- United Healthcare*

Other
- Abigail House for Nursing and Rehabilitation
- Bayada Home Health Care
- Camden Area Health Education Center (AHEC)
- Center for Health Care Strategies
- City of Camden
- Fair Share Housing Development/Fair Share Northgate II
- Greater Newark health Care Coalition
- New Jersey Health Care Quality Institute (NJHCQI)
- Virtua Home Care

Source: Camden Coalition of Healthcare Providers, "Letters of Support: Partners of the Coalition," Application for the Medicaid ACO Demonstration Project, July 3, 2014, https://www.camdenhealth.org/wp-content/uploads/2011/01/ACO-application.pdf, accessed June 2015.

Exhibit 18: The Seven-day Pledge



Source: Nadia Ali, "CRI Follow-Up," email message and documents to Sophia Arabadjis, June 23, 2015.

Patient Access Program: In addition to incentivizing the practices, the Coalition also allocated resources to patients recently discharged from the hospital. Patients received a $20 gift card for attending the initial extended visit as compensation for their time as well as taxi vouchers for efficient transportation. The Coalition reimbursed in this manner deliberately to combat no-show rates due to potential access problems such as hourly jobs, child care needs, and transportation difficulties.

Enhanced Practice Reimbursement Project: With a $26 reimbursement from Medicaid, local practices needed to see eight patients an hour to break even. To ensure adherence and collaboration, the Coalition decided to reimburse an extra $150 to providers who were able to see patients within seven days of discharge from hospitalization for an extended visit, and $100 for providers who were able to see patients within two weeks of discharge.

Source: Compiled by Case Writer.

Exhibit 19: Camden Citywide Diabetes Collaborative Program Goals

THE PROGRAM:

The project seeks to fundamentally change how providers, office staff and community agencies in Camden care for city residents with diabetes by building an accessible, high-quality, coordinated and data-driven health care delivery system with a strong primary care base.

THE GOALS:

- Improve the capacity of community-based, primary care practices to provide comprehensive, proactive care to their patients with diabetes
    - Facilitate the certification of 10 community-based, primary care practices in Camden as Patient-Centered Medical Homes by the National Committee for Quality Assurance (NCQA) and as American Diabetes Association (ADA) Education Recognition Program (ERP) sites
    - Assist practices in implementing a diabetes registry, electronic health records, group diabetes visits, open-access scheduling, on-site nutrition and diabetes education, patient support programs and other tools for effective diabetes management
- Improve diabetes self-management for the residents of Camden
    - Tailor culturally oriented diabetes self-management education programs
    - Expand bilingual (English/Spanish) community health education forums with a focus on diabetes self-management education, nutrition, healthy lifestyles and self-care
    - Implement a monthly series about diabetes self-management on the local cable access channel
    - Distribute audio and video patient education materials to people with diabetes and their families
- Improve coordination of care for people living with diabetes across the city of Camden
    - Develop standard outpatient, emergency department and hospital order sets for the management of patients with diabetes
    - Work with information technology collaborators to develop a citywide diabetes patient registry and chronic disease dashboard

Source: Adapted from Reduce Disparities in Diabetes Informational Website, "Camden Citywide Diabetes Collaborative," http://ardd.sph.umich.edu/camden_coalition_healthcare_providers.html , accessed July 2015.

Exhibit 20: 2008 PCMH Guidelines

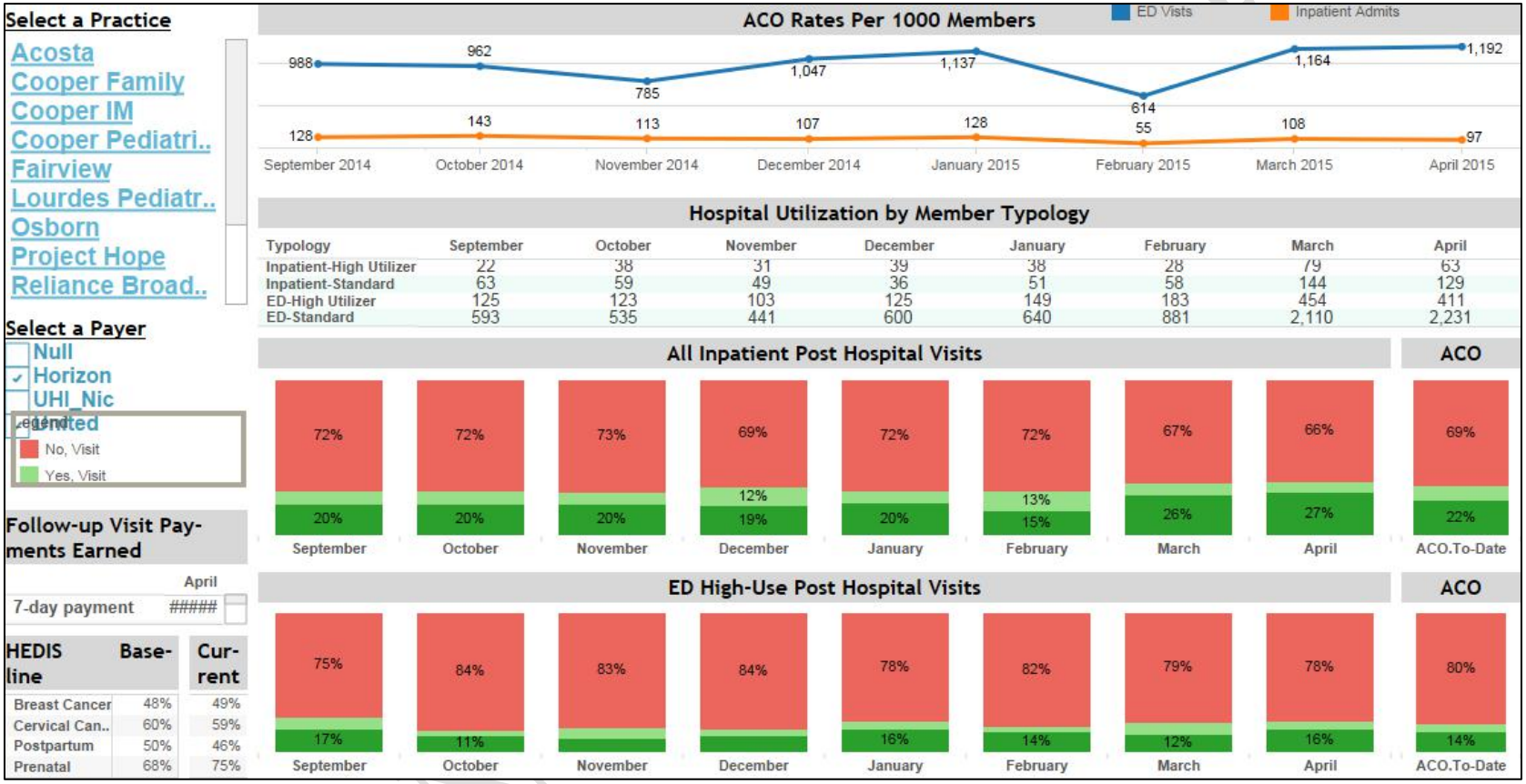
Joint Principles of the Physician Practice Connections - Patient-Centered Medical Home
While early work on the medical home concept was done by pediatricians and focused on care of children with special needs, the concepts embedded in the Patient Centered Medical Home were further developed by a collaboration of the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA). NCQA provided input related to our work on the PPC and a Commonwealth Fund grant to define "patient-centeredness." The joint principles, created and supported by ACP, AAFP, AAP and AOA, define the following key characteristics of the PCMH.
Personal physician—Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
Physician directed medical practice—The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
Whole person orientation—The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care.
Care is coordinated or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.
Quality and safety are hallmarks of the medical home. • Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family. • Evidence-based medicine and clinical decision-support tools guide decision making. • Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. • Patients actively participate in decision making and feedback is sought to ensure patients' expectations are being met. • Information technology (IT) is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication. • Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. • Patients and families participate in quality improvement activities at the practice level.
Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Exhibit 20 Continued: 2008 PCMH Guidelines

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. While aspiring to improve patient care, the four primary care groups envision implementation of the PCMH as linked to more rational (and higher) payment for primary care, which is in very fragile status in the U.S. The four primary care groups, aided by others, have held discussions with employers, health plans and the federal government to encourage the development of PCMH implementation/demonstration programs. In concert with the joint principles, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.
To achieve Recognition as a Patient-Centered Medical Home by meeting the NCQA PPC-PCMH standards, practices will attest to the 2007 Joint Principles of the Patient-Centered Medical Home of the AAFP, the AAP, the ACP and the AOA, as seen below. Practices apply for Recognition with the understanding that the PPC-PCMH standards assess many of the ways in which the practice functions as a patient-centered medical home. Functioning as a patient-centered medical home requires an approach beyond the areas assessed by the PPC-PCMH standards. The concept of the medical home and how to operationalize it is evolving and will result in future versions of the Joint Principles and PPC-PCMH.
NCQA developed the PPC-PCMH to evaluate the extent to which practices are Recognized as medical homes. During 2008, demonstration programs around the country will evaluate PCMHs to answer the following questions: o How many practices can—and will—achieve Recognition? o What quality and cost outcomes are associated with PCMHs? o What are appropriate payment mechanisms for compensating PCMHs?
Demonstration practices will enhance and test PCMH care systems and submit documentation of their experience with the systems. NCQA will collect, analyze and report on PPC-PCMH results. Health plans, researchers, NCQA and others will evaluate the effectiveness of PPC-PCMH as tool for evaluating the quality and resource use of patient-centered medical homes. NCQA also will assess the need for changes in PPC 2006. We anticipate that recommended changes to PPC-PCMH and PPC 2006 will be merged into a single revision of PPC.

Source: National Committee for Quality Assurance, "Standards and Guidelines for Physician Practice Connections® — Patient-Centered Medical Home (PPC-PCMH™)," http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH_Overview_Apr01.pdf, accessed July 2015.

Exhibit 21: Practice Scorecards



Note: The Clinical Redesign Team had access to capitation lists from insurance companies, and so could see patient-provider assignments.

Source: Nadia Ali, "CRI Follow-Up," email message and documents to Sophia Arabadjis, June 23, 2015.

Exhibit 22: Technical Assistance Sites

Location	Name	Funding
Allentown, PA	Neighborhood Health Centers of the Lehigh Valley Super-Utilizer Project	CMMI Healthcare Innovations Challenge Award
Aurora, CO	Metro Community Provider Network	CMMI Healthcare Innovations Challenge Award
Kansas City, MO	Truman Medical Centers Super-Utilizer Project	CMMI Healthcare Innovations Challenge Award
San Diego, CA	Multicultural Independent Physician's Association Super-utilizer Project	CMMI Healthcare Innovations Challenge Award
Boston, MA	Greater Boston Super-Utilizer Pilot Project	Robert Wood Johnson Aligning Forces for Quality Grant
Cincinnati, OH	Cincinnati Super-Utilizer Pilot Project	Robert Wood Johnson Aligning Forces for Quality Grant
Cleveland, OH	Red Carpet Care for Patients in Greatest Need	Robert Wood Johnson Aligning Forces for Quality Grant
Humboldt County, CA	Care Coordination for Emergency Department Super-Utilizers	Robert Wood Johnson Aligning Forces for Quality Grant
Maine	Maine Patient-Centered Medical Home Pilot: Developing Vanguard	Robert Wood Johnson Aligning Forces for Quality Grant
Grand Rapids, MI	Spectrum Health Medical Group Center for Integrative Medicine	Robert Wood Johnson Aligning Forces for Quality Grant
Howard County, MD	Community Based Care Team	Technical Assistance Contract (Graduated)
Houston, TX	Primary Care Innovation Center	Technical Assistance Contract (Current)
San Juan, Puerto Rico	Varmed Management Corp	Technical Assistance Contract (Current)
Joplin, MO	Freeman Health System	Technical Assistance Contract (Current)
Oakland, CA	Sutter Health System, Better Health East Bay	Technical Assistance Contract (Current)
Pittsburgh, PA	UPMC, Community Care Behavioral Health	Technical Assistance Contract (Current)

Source: Sarah Hogan, "Technical Assistance Program," email message to Sophia Arabadjis, December 1, 2015.

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