Reshaping Today's Model of Healthcare Delivery:
A Case for Care Coordination & Collaboration

Yashna Naidu
Washington & Lee University, Class of 2015
POV 423, Winter 2015
Professor Howard Pickett

Abstract: Within this paper, I present an argument for the expansion of coordinated healthcare programs, which provide the greatest potential for improvement in health outcomes for those who are currently receiving the worst care within our present system. Such programs help to carry out our societal obligation to protect the full range of exercisable opportunity and normal functioning for the most vulnerable within our society. Through a close examination of the strategic initiatives of the Camden Coalition of Healthcare Providers that minimize inefficiencies within the present system and target coordinated care toward the worst off within our society, it has become clear that greatly improved health outcomes and lower overall costs are not mutually exclusive. This paper concludes with a recommendation for the expansion of such programs and highlights the benefits of utilizing accountable care organizations (ACOs) to help meet the growing health needs of our country's population.

Reshaping Today's Model of Healthcare Delivery:
A Case for Care Coordination & Collaboration

Reflect on the stories of these two individuals, Flora Wallace and Fay Peterson. Flora Wallace is a 65-year-old senior citizen who struggles to manage multiple long-term health conditions, including diabetes, hypertension, heart issues, and neuropathy. Her chronic health conditions are only worsened by a restricted diet, poor mobility, a lack of safe and reliable transportation around the city, and the high cost of filling her prescriptions. Much like David Shipler's Caroline Payne, Ada is an invisible American filed away as just another heartbreaking story representative of the status quo her high need community. Though she attempts to make it in to her doctor's office as necessary, she often has to forgo recommended follow-up care and treatment on behalf of high out-of-pocket costs. When her symptoms become unbearable, she is forced to seek care from the emergency department because she lacks a reliable source of transportation and her doctor's office is booked for months and months ahead.

Just a few miles down the road lives Fay Peterson, a 55-year-old woman who suffers from severe alcoholism, diabetes, mental illness, and liver cirrhosis among other conditions. Fay had been admitted to local emergency rooms and hospitals nearly 300 times in just one year. Before she was approached by the Camden Coalition of Healthcare Providers, Fay faced a similarly bleak situation, unable to receive care because was not connected to a primary care doctor or even take her medications appropriately because she had not received sufficient instruction when they were prescribed. Fortunately, Fay was recently picked up through hotspotting technologies

within the city's health information exchange and has since been able to receive coordinated care through the Camden Coalition.

Though she was formerly a super utilizer of the emergency department, she has been able to establish a relationship with a primary care doctor through the help of her patient coordinator, who also regularly helps her monitor her weight, blood pressure, blood glucose, and cholesterol. In partnership with her primary care doctor and her patient coordinator, Fay also has gained access to community diabetes self-management classes run by the Coalition's trained diabetes educator, who is able to provide her with nutritional advice and assist her in keeping her blood glucose levels in check. Because her medical records are now maintained in a single location online, her information is shared with her entire medical team and specialists as necessary and the results of all of her medical tests appear in one place. Because she has access to a medical home, she is able to receive much more regular and streamlined care while avoiding duplicated medical services by different doctors as well as unnecessary visits to the emergency department. However, unlike Fay, Flora does not receive access to coordinated primary care, which means that the emergency department has become her primary form of care as a result. The infrequent and disjointed nature of her care means that Flora is only able to seek medical treatment when she is feeling her very worst, which results in extraordinarily high costs and overall largely ineffective attempts at managing her chronic conditions. Although Fay once received similarly fragmented and episodic care which came at an extremely high cost, her conditions are now not only much better managed with the cost of her coordinated care as a whole significantly lowered in comparison – overall, an overwhelming success.

Despite a decade's worth of reforms geared toward providing more continuous care, bettering outcomes, and diminishing costs, the majority of today's health systems remain stuck in their modes of traditional operation and ignore glaring inefficiencies and duplications of services within their present systems. By failing to collaborate sufficiently, health professionals across the board severely diminish the quality of outcomes for patients and health systems alike and miss the opportunity to execute more efficient and effective practices. Undoubtedly, there exists a vital interest in improving the delivery of health care in a nation where the health care sector accounts for nearly one-fifth of the economy. More importantly, given the fact that limited resources exist in terms of health care, it is necessary to pursue delivery models that can increase availability and access to timely care within our population without sacrificing the quality of care in order to accommodate the 45 million Americans today who live without access to a primary care doctor.

Given the limited resources that exist within in our healthcare systems today, trimming inefficiencies in order to provide better quality care at a lower cost has emerged as an essential priority for health providers across the board. Especially when it comes to health systems that work frequently with vulnerable, underserved populations and primarily chronic conditions, there is simply no room for fragmented, episodic, and uncoordinated care. In order to meet today's most pressing healthcare challenges, present times call for a transformed healthcare system in which interprofessional collaboration and coordination are the norm ("Teamwork and Collaborative…"). With increased collaboration and coordination of care, healthcare

providers are able to provide for a better quality of care while reaching an even greater portion of high need patients in need due to the diminished costs from smoothing out inefficiencies. As I come to argue, justice as fairness demands that society provide for the protection and promotion of health and normal functioning, which is an essential ingredient for the protection of fair equality of opportunity for all members of society. Because healthcare is the primary means though which any individual's health needs may be met in our nation, this paper shall focus on highlighting the most effective practices of healthcare delivery targeted toward our nation's most disadvantaged. To do so, I will draw on the key example of the Camden Coalition of Healthcare Providers and the impressive outcomes related to their comprehensive care coordination model. While healthcare systems are not the only things that matter in our efforts to meet our nation's health needs, it is worth recognizing that a healthcare system is currently in place within the United States and it makes sense that it should be structured in the most effective way possible. Consequently, I present an argument for the expansion of coordinated care programs, which provide the greatest potential for improvement in health outcomes for those who are receiving the worst care within our current system, thus meets our obligation to protect the opportunity range of individuals and their normal functioning.

Our Broken System: Highest Costs and Lowest Performance in Healthcare

Even with the most expensive health care system in place, the United States ranks last overall among its peers. In fact, within our system, it is not uncommon for patients

to forgo recommended care and diagnostic tests they need than pay the out-of-pocket associated costs. In reality, the average costs of obtaining appropriate and recommended medical care is prohibitively high for at least four in ten Americans. With this in mind, many are left wondering if the high cost of medical care in the United States is at all justified by the health of its citizens (Mahon and Fox). Unfortunately, the answer seems to be a resounding "no". Health care costs in our nation are far higher than in any other advanced nation and have been rising much faster than the overall economy for nearly half a century. As a result of inflated administrative costs and our reliance on our for-profit, market-based system, our current healthcare system is fraught with obtrusive inefficiencies and coverage gaps because costs have simply spiraled out of hand.

In comparison to eleven other industrialized countries, the U.S. fell in dead last with respect to measures of health system quality, efficiency, access to care, equity, and healthy lives, according to a recent Commonwealth Fund report. Nevertheless, one might expect that a system whose costs equal twice what the next most expensive country spends on health care would have significant better health outcomes within its population. The hard reality is that our life expectancy is shorter and our infant mortality is higher than the vast majority of our peers. Furthermore, in terms of deaths categorized as "potentially preventable" by timely access to effective healthcare, the U.S. still comes in last within this same group. As reported by this same study, Americans experience the most difficulty in affording the health care they need, as more than one-third (37%) of U.S. adults reported forgoing a recommended test, treatment, or follow-up care as a result of cost (Mahon and Fox). In a large part, these extraordinarily high

costs tied present day medical services exist because our current system prioritizes profit-maximization and the rendering of services over good health outcomes. In other words, our present system incentivizes the delivery of treatment over actually working to make patients better overall.

Our nation has witnessed this phenomenon increasingly over time as healthcare has come to be treated as a market commodity, subject to the profit motive just like cars or computers. Moreover, the commodification of healthcare over time has molded into a system that wastes an estimated $750 billion annually on unnecessary services, inefficient care delivery, excess administrative costs, inflated prices, and prevention failures, according to a new Institute of Medicine report (Fung). Put simply, a full third of national spending on healthcare is poured down the drain and lost each year. Needless to say, this view of healthcare hinged upon ability to pay is problematic at best, for it additionally ignores the marginalized individuals that slip through the cracks in the process and deprives them of their fair equality of opportunity. Because of its special moral importance from "contribut[ing] to the range of exercisable and effective opportunities to us", there is no doubt that health ought to be distinguished from other market goods and protected for all within a just society (Daniels 2012, 2). Health care is a fundamental need, not merely a commodity, and should be distributed and provided for accordingly. Health, much like education, is fundamentally necessary for a decent life and ought to be valued as such.

When patients present themselves to their doctors' offices, they come forth in a position of need, not choice. Because health care services are necessary to help make an individual well and regain normal functioning, it is impossible to "shop around" for best deal or even compare rates or models. The truth is that if a patient is in need of medical care, it is needed immediately and patients are expected to pay the price, whatever it may be. For this reason, patients are at the mercy of providers and the market and unable to influence the competition or costs of services, as would be the case in a free-market model (Levine-Rasky 2002). Moreover, patients on average certainly do not have sufficient knowledge or understanding of health mechanisms and procedures to make an informed consumer choice. As a result, they place high levels of trust in their physicians in order to guide them in the management of their health. For this reason, the profit motive is inappropriate in the context of healthcare, as it may compromise a doctor's fundamental commitment to the health of his patients on behalf of profit maximization. For instance, a health care provider motivated by profit might be more inclined to prescribe more medications for a particular diagnosis or recommend more costly diagnostic testing or more expensive medical interventions than usual. Rather, we expect that our health care providers help us because they maintain an active interest in our health and well being, not because we pay them more than someone else who would receive inferior care as a result. Ultimately, by treating healthcare solely as a commodity that exists to drive the economy and be sold in efforts to maximize profit, incentives within the system are targeted incorrectly, which only worsens outcomes for the worst off and most vulnerable within our society.

Why Do We Value Health?

Without a doubt, the best way to approach these alarming issues within our current system is by reflecting on the fundamental question of what we truly owe each other. Under a Rawlsian perspective of social justice, a just society exists when all people are assured the protection of equal access to liberties, rights, and opportunities for living healthy and fulfilling lives. Rawls's key theory of social justice is often referred to as "justice as fairness", which promotes the obligation to ensure the fair allocation of community resources and taking care of the least advantaged members of society. Still, it is a commonly accepted idea that when the core needs of the most vulnerable are supported, the economy and society by extension are weakened as a result. In fact, the converse is much more probable. By ensuring that the core set of social goods and services necessary to protect an individual's full range of opportunity are accessible, including health care, education, housing, and food, the strength of society overall is bolstered.

In order to achieve justice within a society, Rawls maintains that there exists a collective obligation to provide for the fair equality of opportunity for all members of society. Because health exists as both central capability and a prerequisite to opportunity, justice requires that society protect robust health in order to protect the range of opportunities that people can exercise, also known as normal functioning, and preserve fair equality of opportunity. In addition, it is worth noting that a variety of socially controllable factors contribute to maintaining normal functioning and the

"protect[ion] the range of opportunities that individuals can reasonably exercise" (Daniels 2013). According to Norman Daniels, "since meeting health needs protects the range of exercisable opportunities, then any social obligations we have to protect opportunity imply obligations to protect and promote health" (Daniels 2013). By ensuring that all individuals within society are able to have their health needs met, society provides access to a full range of exercisable opportunity necessary for a decent and dignified life. While critics may respond by drawing attention to the limited resources and capacity of our current system and claiming that these obligations realistically cannot be met, this does not mean that reasonably good efforts toward leveling the playing field of health outcomes should not be made. In reality, these concerns may be alleviated by a more effective allocation of existing resources through the minimization of systemic inefficiencies and superfluous overhead costs as well as increased collaboration within and across various clinical settings.

Improving Health Outcomes Through Care Coordination in Camden

Contrary to popular belief, high quality care and low costs are not mutually exclusive. In fact, strategic initiatives like the Camden Coalition of Health Providers (CCHP) created with the mission of "improving the quality, capacity, and accessibility of the healthcare system" for the city's most vulnerable populations work vigorously to dispel that myth ("History of the Coalition"). Through executing a model of comprehensive care coordination and a data-driven practice called "hotspotting", CCHP works actively to both increase the quality of care for Camden's patients while cutting

down healthcare costs. Working with this organization in the summer of 2014 provided me with key insight into how powerful comprehensive care coordination can really be in combatting complex, negative health outcomes and effectively addressing patients' needs both medically and socially.

As it turns out, healthcare spending in the United States is extraordinarily unevenly distributed: a mere five percent of the population accounts for more than half of the nation's healthcare spending. In the city of Camden, roughly twenty percent of patients translate to ninety percent of medical costs in the city. Most notably, the lack of coordination and duplication of highly expensive services that result from not having a widely available and centralized medical home are what brings about such a large burden on healthcare systems. All together, these individuals account for nearly $30 million in medical spending annually, though it is worth noting that those with the highest medical costs are commonly those also receiving the worst care. According to Dr. Jeff Brenner of CCHP, the mind behind the clinical practice of hotspotting, "emergency-room visits and hospital admissions should be considered failures of the health-care system, of prevention, and of timely, effective care until proven otherwise" (Gawande 2011). Furthermore, so many of the conditions that are the cause for emergency department and hospital visits are easily treatable in a primary care setting. In fact, the top three reasons for hospital visits in Camden were head colds, viral infections, and sore throats. Upon further reflection, it is clear that a particular kind of patient is consuming healthcare treatment within this city at an astonishingly high rate yet still not getting healthy. Even more appalling is the fact that healthcare delivery systems are

set up to actually profit from these "super utilizers", and they do so at the expense of taxpayers (Dubner). This is precisely where the Camden Coalition steps in to intervene and correct for such failings in patient care within the system. Through its skilled use of health information technology and patient navigation, application of a trauma-informed approach to care, and promotion of patient-centered medical homes, CCHP's focus on care coordination within an immensely underserved city has helped it emerge as a key leader in effective healthcare delivery within our nation.

Through the use of a citywide patient database also known as the Camden Health Information Exchange (HIE), CCHP utilizes a unique data-driven process called hotspotting that identifies and targets super-utilizers of the city's healthcare system who frequently cycle in and out of the hospital. Not surprisingly, the complex medical needs of these patients are not much closer to being met through the fragmented care received in emergency departments. The composition of this super-utilizer group is diverse, though many within the group share highly complicated and intertwined health and social issues as well as high rates of emergency department and hospital use. In addition, some may not only lack necessary financial resources and insurance but also a sufficient understanding of how to use the healthcare system. Most importantly, these individuals have no source of regular, coordinated medical and social services, which is precisely what they need to protect and ensure stable health ("Better Care for…").

In response, the Camden Coalition takes on a collaborative and comprehensive approach through the use of care management teams to help these super-utilizer

patients better manage their physical and mental health. According to the Robert Wood Johnson Foundation, since 2005, CCHP has managed to half the average monthly hospital charge for their super-utilizer patient population (from $33,333 to $14,597) and also cut their number of emergency department visits in half annually (Huget). This approach yields such impressive results through the work of these proficient care management teams, which are composed of a nurse practitioner, a social worker, and a health coach and supplemented by a primary care physician. Each team works to develop coordinated solutions for each individual patient in order to streamline plans of care, ensure secure transportation to medical visits, assist with government assistance applications, obtain temporary shelter, and ultimately reintroduce the individual to a primary care provider (PCP) to reduce the likelihood of return to emergency care. By working to ensure better coordination of health care for these particular individuals through actively monitoring the HIE and tackling chronic conditions through a team-based approach, CCHP is not only able to help stabilize medical conditions and social environments but also reduce hospital visits and drastically downsize medical costs.

Incorporating a Trauma-Informed Approach into Healthcare Delivery

Especially within homes affected by poverty, stressful and traumatic experiences like home instability, food insecurity, family dysfunction, abuse, and neglect remain very prevalent, though the effects of these experiences are rarely factored into medical interventions today. In addition, both high levels of ongoing stress and adverse childhood experiences seriously shape health and general well-being throughout an

individual's lifetime. Sadly, such effects on an individual's health often begin early in life and accumulate over the course of a lifetime, frequently resulting in devastating health outcomes later in life. In a recent study called the Adverse Childhood Experience (ACE) study, Drs. Vincent Felitti and Robert Anda found that some of the very worst health and social problems in our nation can be traced directly as a consequence of adverse childhood experiences. Through comprehensive psychosocial analysis and the responses to a questionnaire, they uncovered a direct link between the extent of an individual's adverse childhood experiences, like abuse, neglect, and family dysfunction, and host of negative later-life health outcomes. By assessing the total amount of stress experienced during childhood and determining an individual's numerical ACE store, Drs. Felliti and Anda were also able to identify the individual's risk for a multitude of serious health problems later in life. In short, particular early life experiences exist as key indicators and major risk factors for the leading causes of death and illness as well as poor quality of life in the United States (Felitti and Anda 1998, 245).

With knowledge that particular social factors and early life experiences directly correlate to overwhelmingly negative health outcomes, there exists an even stronger obligation for society to step in and take a stand against such injustices. However, as it stands today, doctors are not ordinarily educated about the effects of early life trauma or ACE scores in medical school or trained, let alone trained to interpret the long-term effects of such adverse experiences in the context of a clinical setting. Additionally, no standard protocol for what a doctor should do with the results currently exists, though the Camden Coalition certainly believes that this should no longer be the case. While

some physicians question the usefulness of the test's scores as similar diagnoses would likely be made regardless, proponents of the ACE test insist that they have missed the importance of understanding health status in the greater context of an individual's life experiences.

According to Dr. Brenner of CCHP, understanding and interpreting these measures of adversity from patients has the potential to "help the whole health care system understand patients better" (Starecheski). He maintains that the ACE score is still the best predictor for health spending and utilization and gives health professionals a much better idea of a patient's risk for many of the major health problems that affect Americans today, like heart disease, diabetes, depression, and addiction. The question remains then: with the knowledge that particular factors and experiences in an individual's life are strongly connected to negative life outcomes down the line, what exactly can and should be done to make a difference in patients' lives? At the very least, with a patient's individual ACE score in mind, a doctor may know to be more vigilant with diagnostic testing and preventative measures or even just more attentive to the external factors that may be actively impacting his patient's health. In this same way, physicians may be able to gain a much clearer picture of the overarching context surround an individual's present state of health and preserve and promote the autonomy of patients who may otherwise see their autonomy threatened by the constraints and problems not traditionally treated in a clinical setting.

Slowly but surely, the Camden Coalition has set to work educating providers in the Camden area on the far-reaching effects of trauma and how to best serve their patients with this greater context in mind. By integrating this powerful tool into practice in the context of a patient's personal health story, healthcare providers are much better equipped to deliver more efficient and effective comprehensive care while acting as agents of public health, as opposed to just clinicians. Especially through the CCHP's delivery of trauma-informed comprehensive and coordinated care, the organization has demonstrated that it can effectively moderate the effects of these adverse experiences by improve health outcomes for vulnerable populations.

Health Benefits of Continuous, Preventative Medical Care

While a substantial portion of CCHP's efforts center upon reducing the unnecessary usage of emergency health services, another key focus is helping recently discharged patients establish relationships with primary care providers, emphasizing the crucial importance of regular and ongoing preventative medical care. These efforts are particularly indispensable within a high need population like Camden's, as there exists a high prevalence of unmanaged chronic conditions within the population that are left to progress unchecked over time. When left uncontrolled, chronic conditions can severely compromise an individual's quality of life, lead to lifelong disability and crippling medical bills, and even bring about preventable death. While the advancement of medicine has drastically reduced the prevalence of many acute conditions, chronic disease has become the nation's leading cause of mortality, accounting for seven of every

ten deaths among Americans. In addition, caring for chronic diseases, diseases driven by risk factors that are generally preventable through regular and ongoing medical care, accounts for more than 75% of the nation's health spending (CDC). That being said, even though most Americans currently underuse preventative care services, individuals who are affected by socioeconomic disadvantages are *even less* likely to use these services. However, as it has long been said, prevention is better than treatment, as opportunities for prevention impact all Americans, regardless of age, income, or perceived health status (CDC).

During my time with the organization, I observed a particularly effective strategic initiative geared toward reducing hospital readmission rates and promoting the use of ongoing, preventative care. This program, called the 7 Day Pledge, is led by the organization's care management teams and actively encourages primary care offices to see recently hospitalized patients within seven days of their hospital discharge to ensure good transition care from hospital to primary care. Based on data from a related pilot program targeting super utilizers, CCHP found that patients who were able to see their primary care doctor within seven days of hospital discharge were significantly less likely to be readmitted to the hospital (CCHP, "Outreach"). Many large, urban communities would benefit from having access to such programs that ensure a smooth transition from hospital bed to home and help patients understand how they can best follow discharge instructions to remain healthier and out of the hospital for much longer. Most importantly, the emphasis placed upon the importance of utilizing primary care to

manage chronic conditions is a essential component towards bettering the long term outcomes of patients and the great success of such programs.

As seen through successful efforts by CCHP, through the use of preventative care, patients are better able to work in partnership with healthcare providers to control risk factors and therefore reduce the incidence of costly chronic conditions (Goodell, Cohen, and Neumann 1). A focus on prevention additionally allows for greater numbers of at risk individuals to be brought into the care of healthcare providers and serves as an excellent long-term investment in our future. Though some in opposition might categorize preventative care as gratuitous medical spending, the benefits in comparison to lengthy hospital stays, emergency room visits, and costly medications after disease has set in will more than likely pay off during an individual's lifetime. In the same capacity, while any savings achieved through prevention are indeed beneficial, it is important to not lose sight of the actual goal of prevention – the betterment of an individual's health and quality of life.

Importance of Health Navigators for Complex, High Need Patients

While expanded implementation of coordinated care and its many facets will certainly help to ameliorate health outcomes and minimize unnecessary spending, these efforts alone are not enough. In the context of a rapidly changing healthcare environment, many have difficulty accessing and navigating the complexities of the US healthcare delivery system. Without sufficient knowledge and understanding of how the system actually works, these individuals are likely to slip between the cracks, unable to

advocate for themselves or gain the appropriate quality or type of care they need and deserve. To bridge this gap for vulnerable or underserved populations, a health navigator can be introduced, not only facilitate better access to quality care through advocacy and care coordination but also "address deep-rooted issues related to distrust in providers and the health system that often lead to avoidance of health problems and non-compliance with treatment recommendations" (Pereira *et al.* 3541). As a result, these patient navigators can help their patients to gain a better understanding of how the healthcare system works and ultimately establish relationships of trust with their primary care providers. Within the Camden Coalition, these navigators are referred to as "health coaches", who serve as the primary point of contact for patients for all of their non-clinical needs. For instance, this can include working with insurance companies on behalf of patients, obtaining appointments in a timely manner, arranging transportation to and from appointments, and even attending appointments alongside patients.

During my time spent conducting patient satisfaction surveys in the physician's offices and waiting rooms of Camden, it was apparent that there was a blatant disconnect between those that are and are not a part of the system. Especially in large, urban communities like Camden with high underserved portions of the population, waiting rooms are overcrowded and poorly monitored, receptionists are almost consistently occupied and overworked, and providers are largely stressed and overextended. Consequently, many Camden residents exhibit feelings of dispossession toward the healthcare system and utilize it in a large part as a "last resort" mechanism. With the introduction of health coaches into the picture, however, patients are able to

get a much better sense of control over their health conditions and encounters and eventually come to view the health institutions as also their own. Through the practice of patient empowerment, health coaches work to build strong relationships with their patients, supplement their individual autonomy, and educate them on how to utilize their medical resources to the best of their ability.

The ultimate goal of this key relationship is to help patients to get back on their feet and feel comfortable advocating for themselves in all healthcare encounters, which proves to be a crucial step in the right direction and an exceptionally worthwhile investment in the future of our nation's health time after time. Within the group of pilot patient navigation programs in place currently across the nation, the cost savings were almost immediate. In the yearlong patient navigation pilot program at MetroHealth Medical Center's Cancer Care Center, two full-time navigators were put in place to guide patients through their healthcare experience within the system. Within the first three months of the program, the reduction in the number of "no-show" appointments amounted to the equivalent of the salary for a navigator for an entire year. Intended to make it easier for patients and their families to navigate the healthcare system regardless of economic or social status, navigation programs allow practices to "save valuable resources for their intended use" and ought to receive greater public support across the nation to improve the efficiency and effectiveness of our healthcare systems (Townsend).

Transition Toward Accountable Care Organizations

While CCHP's care coordination efforts thus far offer compelling evidence of preliminary successes and great potential for long-term savings, Dr. Brenner reflects that "such community-based endeavors are difficult to initiate and sustain without start-up financing, ground-level technical assistance, and buy-in from state and local policymakers, health plans, patients, and community members" (Brenner and Highsmith). At least in some capacity, a shift in the delivery of primary care toward incorporating the model of the patient-centered medical home could alleviate some of this costly burden. As defined by the American Academy of Family Physicians, the concept of the medical home involves a "transition away from the model of symptom and illness based episodic care…toward an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive and chronic care management through all stages of life" (AAFP). This model of primary care is comprehensive, team-based, patient-centered, coordinated, accessible, and focused on both quality and safety. Current efforts in building relationships within the Camden health provider network have been major steps toward creating such partnerships and encouraging communication across and within various clinical settings in the Camden area. Through this team-based model, providers are encouraged to collaborate rather than compete with one another to establish stronger relationships with their patients while providing continuous and comprehensive medical care.

Ultimately, the goal is for healthcare providers to meet patients exactly where they are regardless of the complexity of their condition and for patients to obtain

maximized health outcomes. This team of healthcare professionals is responsible for the coordination of a patient's care across all health systems, which is made possible through health information exchanges and clinical support tools that guide decision-making to ensure that patients receive timely and effective care when needed. Interestingly, many of these features are present in the Coalition's current efforts, especially as they work toward becoming an accountable care organization (ACO) which will help them benefit from greater governmental funding. ACOs are a model of care created through the Affordable Care Act in 2010 that are patient-centered and utilize a well-staffed group of primary care providers as a first line of defense. This model utilizes a team-based approach of doctors, hospitals, clinics, home health aides, and health navigators who assist in care management and voluntarily commit to shared responsibility for patients' health. Ultimately, this team also shares in the anticipated savings and benefits based on successful outcomes from patients. These innovatively targeted incentives set this model apart from the traditional fee-for-service model of healthcare and make for greater quality and outcomes with diminished medical costs ("Camden Coalition Tackles…") Because good outcomes and provider collaboration are incentivized over the number of patients or services that can be run throughout the day, the overall well being of patients is improved with substantially better long-term costs of care in the end.

Room for Growth

At the end of the day, it is still clear that there is no silver bullet for containing and restraining today's sky-high health care costs. However, recognizing what we owe one another in terms of the protection of fair equality of opportunity, we need to ensure that healthcare services are both affordable and accessible for all members of society, especially the most vulnerable. With their healthcare delivery model of care coordination, the Camden Coalition certainly provides an effective way to improve the quality of patient outcomes while minimizing unnecessary medical costs and allowing for a more effective distribution of services across the board. In its decade of existence, CCHP has become one of the essential community organizers within the Camden healthcare provider network by building strong relationships across the city's provider community. With the combination of these cultivated relationships and shared information technology between the city's health partners, Camden healthcare professionals are now able to utilize the HIE to both improve patient care and diminish medical costs by way of care coordination and collaboration.

With such overwhelming success within the program so far, a key question remains how one might go about implementing and expanding such collaborative programs across the nation. According to Hong, Siegel, and Ferris of the Commonwealth Fund, effective programs "customize their approach to their local contexts and caseloads; use a combination of qualitative and quantitative methods to identify patients; consider care coordination one of their key roles; focus on building trusting relationships with patients as well as their primary care providers; match team composition and interventions to patient needs; offer specialized training for team

members; and use technology to bolster their efforts" (Hong *et al.*1). With these key components present in a program within a large, urban environment, there exists a high potential for success through care coordination and the implementation of the medical home model. While it will not explicitly be addressed in this essay, healthcare professionals might wonder if the high needs population must be of certain size to ensure that programs of this nature will be viable. Though it is true that the most dramatic cost reductions will be seen when super-utilizers are targeted, the size of the particular high needs population is not of the utmost importance because this form of care is desirable and beneficial to all populations and provides for maximized health outcomes.

Enduring Questions

By continuing to implement and expand programs that combine the key features of comprehensive care coordination, increased collaboration, and patient navigation, I remain optimistic that our nation's healthcare system will begin to see greater inclusion and health outcomes for at risk, underserved populations. This approach is certainly one effective way to respond to meeting the health needs of those within society whose opportunity is not sufficiently promoted or protected. Most commonly, these super-utilizing populations are the worst off within society who often also have the greatest potential to be neglected within our current health system. At the same time, it is worth noting that this group is not the only group whose health and ability to meet health needs are compromised. There are certainly individuals within the population whose

health and ability to meet health needs are less than optimal – those who are not the worst off but yet still are not well off themselves. With that in mind, one might seek to establish what exactly the right relationship is between coordinated care and these groups of people. At the same time, it is worth considering whether such programs like the CCHP's coordinated care initiatives might divert energy and efforts within the healthcare system to the detriment of premium healthcare recipients or even adversely affect their health outcomes. In response to this concern, I shall point to many of the strategic initiatives implemented by CCHP and other ACO-like organizations that work to minimize inefficiencies within the current system, such as duplications of tests and services, failure to collaborate within a healthcare network, and prevention failures, which arguably allows for a more effective delivery of healthcare. By minimizing these inefficiencies, current healthcare systems will be able to better control and allocate their resources while managing their current patient loads more fluidly. Furthermore, one might wonder if it is actually reasonable to attempt to scale up coordinated care programs to a national level. While such programs do require comparatively high start-up costs and resource-intensive efforts, the long term savings and drastically improved health outcomes within the population more than make up for these initial high costs. Similarly, a final notable challenge will be cultivating the necessary political support for such transformative programs, as the current system provides strong incentives to those currently with the greatest power and authority. Still, I remain confident that so long as present efforts to incorporate greater care coordination in health delivery can be

sustained, their outcomes and net savings will serve as compelling evidence to secure support for expanding such programs.

Works Cited

American Academy of Family Physicians. "Patient-Centered Medical Home." *AAFP*. Web. 9 Mar. 2015.

"Better Care for Super-Utilizers." Robert Wood Johnson Foundation, 31 Oct. 2012. Web. 6 Mar. 2015.

Brenner, Jeffrey, MD, and Nikki Highsmith. "An ACO Is Born in Camden, But Can It Flourish in Medicaid?" *Camden Coalition of Healthcare Providers RSS2*. N.p., 23 June 2011. Web.

Camden Coalition of Healthcare Providers. "History of the Coalition." *CamdenHealth.org*. 12 Dec. 2010. Web. 12 Mar. 2015. < http://www.camdenhealth.org/about/about-the-coalition/history/>

Camden Coalition of Healthcare Providers. "Outreach." *CamdenHealth.org*. 12 Dec. 2010. Web. 12 Mar. 2015. <http://www.camdenhealth.org/about/community-organizing/>

"Camden Coalition Tackles the High Cost of Healthcare." *Camden Coalition of Healthcare Providers*. N.p., 07 Mar. 2012. Web.

Chen E, Martin AD, Matthews KA. Socioeconomic status and health: do gradients differ within childhood and adolescence? Soc Sci Med 2006;62(9):2161-70.

C. S. Hong, A. L. Siegel, and T. G. Ferris. *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* The Commonwealth Fund, August 2014.

Daniels, Norman. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge UP, 2008. Print.

Daniels, Norman."Justice and Access to Health Care", *The Stanford Encyclopedia of Philosophy* (Spring 2013 Edition), Edward N. Zalta (ed.), <http://plato.stanford.edu/archives/spr2013/entries/justice-healthcareaccess/>.

Felitti, Vincent J., and Robert F. Anda. "The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare." *The Impact of Early Life Trauma on Health and Disease the Hidden Epidemic*. By Ruth A. Lanius, Eric Vermetten, and Clare Pain. Cambridge, UK: Cambridge UP, 2010. Print.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 1998;14:245–258.

Fung, Brian. "How the U.S. Health-Care System Wastes $750 Billion Annually." *The Atlantic*. Atlantic Media Company, 07 Sept. 2012. Web.

Gawande, Atul. "The Hot Spotters." The New Yorker, 24 Jan. 2011. Web. 02 Feb. 2015.

Huget, Jennifer LaRue. "'Super-utilizers' Place Huge Burden on Health-care System." *Washington Post*. The Washington Post, 22 Oct. 2012. Web. 12 Mar. 2015.

Levine-Rasky, Cynthis. "Six Reasons Why Health Care Is Not a Commodity." *Canadian Dimension*, September/October 2002.

Mahon, Mary, and Bethanne Fox. "US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives." The Commonwealth Fund. June 16, 2014. http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last.

Natale-Pereira, Ana, Kimberly R. Enard, Lucinda Nevarez, and Lovell A. Jones. "The Role of Patient Navigators in Eliminating Health Disparities." *Cancer* 117.S15 (2011): 3541-550. Web.

"Preventive Health Care." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 12 June 2013. Web. 12 Mar. 2015.

Sammen, Joe. "High Utilizers of Our Health Care System Matter." *KevinMD.com*. 08 Sept. 2013. Web. 02 Feb. 2015.

Starecheski, Laura. "10 Questions Some Doctors Are Afraid To Ask." NPR, 3 Mar. 2015. Web. 12 Mar. 2015.

"Teamwork and Collaborative Decision-Making Crucial to Health Care of the Future." Robert Wood Johnson Foundation, 28 Nov. 2011. Web. 11 Mar. 2015.

Townsend, Angela. "Patient Navigators Find Role in the Local Health Care System." *Cleveland.com*. 9 Oct. 2012. Web. 13 Mar. 2015.